



Migration and HIV in the Republic of Belarus



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CHAPTER 1. OVERVIEW

The relationship between cross-border migration and the spread of infectious diseases, such as HIV, has been the subject of research in various regions of the world, including the republics of the former USSR. Although the movement of people between countries *per se* does not increase the likelihood of infection, it is related to the circumstances and behaviour patterns conducive to HIV transmission (Martin, 2011; Inkochosan et al., 2015). In particular, this concerns violations of sanitary norms in the provision of medical services to migrants, as well as migrants' engagement in unsafe sexual behaviour and intravenous drug use. In some cases, risky behaviour is a reaction to stressful conditions in which migrants find themselves in the country of destination; in others, they are indicative of restricted access to health care; and some migrants are vulnerable to the temptations that come with the weakening of family and community ties. While HIV prevalence among those who moved to CIS (Commonwealth of Independent States) countries from abroad is not higher than among the general population, the empirical data generated in this research suggest cases of migrants having unprotected sex, as well as having several sexual partners, including those engaged in providing sexual services for money. Immigrants also face difficulties in obtaining medical care, which is associated with its high cost, bureaucratic restrictions, discrimination and poor knowledge of the language (Steffan and Sokolowski, 2006; Dzhuraev, 2009; Amirkhanyan et al., 2011; Grushetsky, 2013).

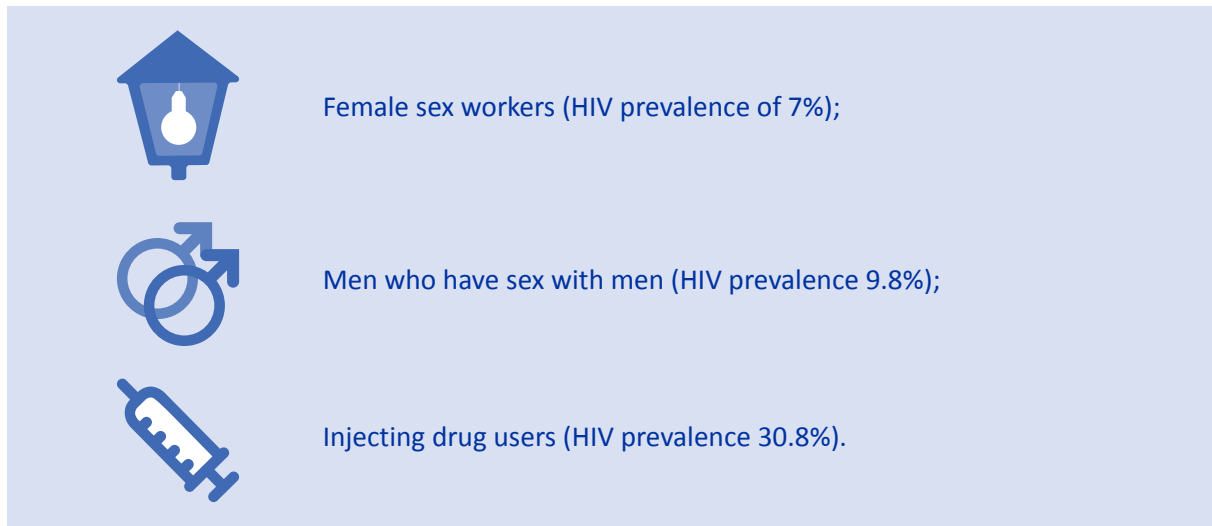
The Joint United Nations Program on HIV/AIDS (UNAIDS) recognizes migrants as a "risk group" for HIV, noting in its report the social restrictions mentioned above as conditions conducive to the epidemic (UNAIDS, 2014). The report further recommends to improve the interaction between the health services of the countries of departure and destination, and also to develop a set of preventive and therapeutic measures that take into account the needs of migrants, as the primary steps of response to address HIV among this social group. This requires a careful calibration of relevant activities, aimed at factors that influence the spread of HIV among migrants within a particular country necessitating an assessment of the HIV situation among the group.

Given the high prevalence of HIV in Eastern Europe and Central Asia, an analysis of the relationship between migration and HIV in Belarus is reasonable and a timely initiative. Not only is Belarus situated in the only region of the world where the HIV epidemic continues to rise at a concerning rate, but it also borders the Russian Federation and Ukraine, the countries with the highest number of registered HIV cases in Eastern Europe. In 2016, there were more than 1 million people infected with HIV in the Russian Federation, with a significant portion of them infected via sexual contact (Pokrovsky, 2017). Similar tendencies can be observed in Ukraine, that has more than 300 thousand patients with HIV, and where sexual contact has been the number one mode of transmission since 2008.¹ Donetsk and Luhansk are among the regions with the highest HIV prevalence, and there the military conflict led to an exodus of residents to neighbouring countries, including Belarus. In Ukraine, this resulted in the emergence of HIV strains typical to Donbass in the central and western regions of the country (University of Oxford, 2018). Also of notice is that a significant part of Belarus' population in economically active age goes to work in neighbouring countries, primarily to the Russian Federation. Moreover, Belarus' educational cooperation with other countries remains robust, with thousands of international students coming to study at Belarusian universities every year.

¹ The data on the prevalence of HIV in Ukraine comes from the Center for Public Health of the Ministry of Health of Ukraine, as reported in the website of the Anti-AIDS organization. HIV in Ukraine: Statistics as of November 1, 2017. Available from www.antiids.org/news/aids_stat/spid-v-ukraine-statistika-na-01112017-11214.html (Accessed on 26 September 2018).

1.1. HIV in Belarus

As of 1 September 2017, Belarus had registered 23,702 cases of HIV, or 194 per 100,000 population based on the report from Belset – AntiAIDS, 2017. With a prevalence of 0.2 per cent, the HIV epidemic is in a concentrated stage and mainly affecting certain “risk groups” rather than the general population. The 2017 Sentinel Surveillance Study for HIV prevalence (Kechina, 2018) found the **highest infection rates among the following groups:**



Belarusian researchers singled out two stages in the development of the HIV epidemic in the country: The first stage (1986–1996) is characterized by the predominance of the parenteral² transmission mode, with teenagers and young adults aged 14 to 24 who lived in the towns of Svetlogorsk and Zhlobin (Gomel region) being the most affected group. In the second stage (1997–2010), the heterosexual transmission route dominated, with two-thirds of the cases of HIV occurring in the age group of 19 to 29 years, and infections penetrating 198 administrative units of Belarus, although HIV prevalence in Svetlogorsk remains the highest (Ereminet et al., 2010).

Overall, HIV transmission through heterosexual contact remains the predominant mode, accounting for 61.2 per cent of HIV infections registered between 1987 and 2017. Another 36.6 per cent of patients were infected through contact with contaminated blood – usually via injecting drug use. In recent years, heterosexual transmission has been increasing, accounting for about 76 per cent of HIV cases registered between January and August 2017. Consequently, HIV is concentrated among young and middle-aged people; 93 per cent of infections occur among people aged 15 to 49. Women account for 40 per cent of HIV patients, and the proportion is increasing (HIV Situation in Belarus as of 1 September 2017). Since 2008, the number of HIV new cases registered in Belarus has been increasing and currently exceeds the average European rate but is still much lower than in the neighbouring Russian Federation and Ukraine (Chart 1).

Regional distribution of registered HIV cases varies considerably. Gomel region is the most affected one, accounting for 77.6 per cent of HIV cases registered in Belarus. Minsk region (206 cases per 100,000) and the city of Minsk (200 cases per 100,000) are also among the affected regions.

² Parenteral transmission is defined as “subcutaneous, intramuscular or intravenous contact with blood or other body fluid of an HIV-1 infected individual”.

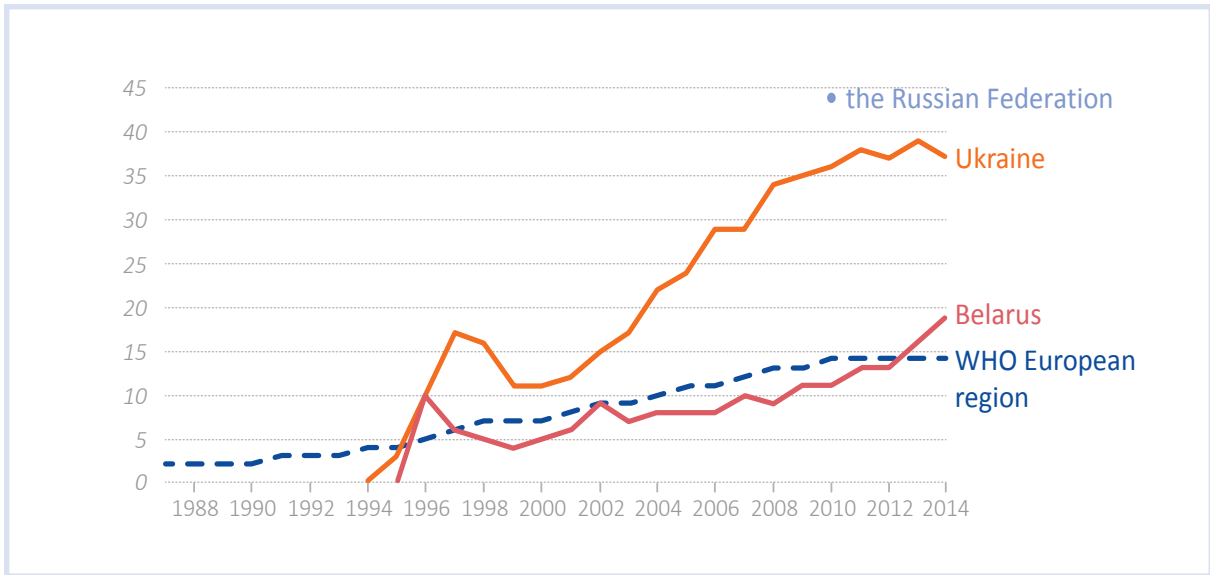


Chart 1. HIV prevalence per 100,000 population

1.2. Measures to prevent and treat HIV

Measures aimed at limiting the consequences of and ultimately defeating the HIV epidemic are implemented within the framework of the State programme “People’s Health and Demographic Security, 2016–2020”, that contains a section on countering the spread of HIV. In particular, it emphasizes the importance of universal access to HIV diagnostics and treatment; elimination of cases of nosocomial infection and transmission of HIV from mother to child; decrease in the prevalence of HIV among “risk groups” such as injecting drug users and their sexual partners; commercial sex workers; men who have sex with men; prisoners, as well as “difficult” adolescents.



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Among the priorities of the HIV prevention policy, note should be taken of providing patients with relevant clinical indications with continuous access to antiretroviral therapy, which allows not only to improve the quality and duration of their life but also to reduce the spread of the disease. In particular, interdisciplinary teams and social support centres for HIV-infected people have been established in the country, promoting treatment adherence among them. To reduce the risk of mother-to-child transmission of HIV, centres for the provision of comprehensive services to families with HIV-infected patients have been opened. Centres for voluntary counselling, testing and social support are in place for injecting drug users and sex workers, i.e. in groups where HIV infection is most common. At the same time, there is an interdepartmental information strategy on HIV/AIDS aimed at disseminating knowledge on HIV prevention, with – among other things – awareness-raising events being conducted for students at educational institutions and HIV prevention programs offered at workplaces (National HIV Prevention Progress Report, 2015). It should also be noted that until 2015 a large part of preventive and treatment interventions, as well as patient care and support programs were funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, which raises concerns about their sustainability (Lundgrenand et al., 2014). However, over the past two years, state funding had been significantly increased, and by 2017 the whole spectrum of medical care for HIV was covered by internal sources.

Access of foreign citizens to medical assistance is regulated by Article 5 of the Law of the Republic of Belarus “On Health Care” of 18 June 1993. The law establishes the right of foreign citizens and stateless persons permanently residing in the Republic of Belarus (who have received a permanent residence permit) to affordable medical care on an equal basis with the citizens of the Republic of Belarus unless otherwise specified by laws and international treaties. Also, foreign citizens and stateless persons who temporarily stay or temporarily reside in the Republic of Belarus are entitled to have access to affordable medical services at their own expense, funds of legal entities and other sources not prohibited by the legislation of the Republic of Belarus, unless otherwise established by its laws and international treaties. The same provisions are contained in the Law of the Republic of Belarus “On the Legal Status of Foreign Citizens and Stateless Persons in the Republic of Belarus” of 4 January 2010 and the Law of the Republic of Belarus “On State Social Benefits, Rights and Guarantees for Certain Categories of Citizens” of 14 June 2007 and the Law of the Republic of Belarus “On Social Protection of Persons with Disabilities in the Republic of Belarus” of 11 November 1991. Thus, foreign citizens that are temporarily staying and temporarily residing in the Republic of Belarus receive medical care on a paid basis mostly, unless otherwise stipulated by international treaties. At present, the Republic of Belarus has signed a number of international treaties that regulate the issues of providing emergency and urgent medical assistance, as well as planned medical care. The conditions for access to medical care for specific categories of migrants are listed in Annex 1.

1.3. Migration situation

As of 31 December 2016, there were 52,800 foreign citizens in Belarus who had a temporary residence permit (17,600 of them came to study), as well as 176,500 who received documents for permanent residence in Belarus.³ Thus, foreign citizens in Belarus make up about 2.5 per cent of its population. At the same time, some of them are engaged in labour activity. In 2016, 19,939 pertinent permits were issued or extended. They were issued mainly in Minsk (10,476) and Minsk region (2,122), as well as in the Gomel region (3,080). Among the recipients of these permits, Chinese (7,459) and Ukrainian citizens (6,348) are leading.

³ Statistical summary provided to authors by the Ministry of Interior by an official letter, issued on 30 November 2017.

On the other hand, approximately 2 per cent of Belarusian citizens of working age went to temporary work abroad. The main flow of outgoing labour migrants was to the Russian Federation (89.5%), as well as EU countries. The share of those who went abroad in search of work is higher in the regions bordering the Russian Federation: Gomel, Mogilev and Vitebsk (National Statistical Committee, 2016) (see Figure 1).

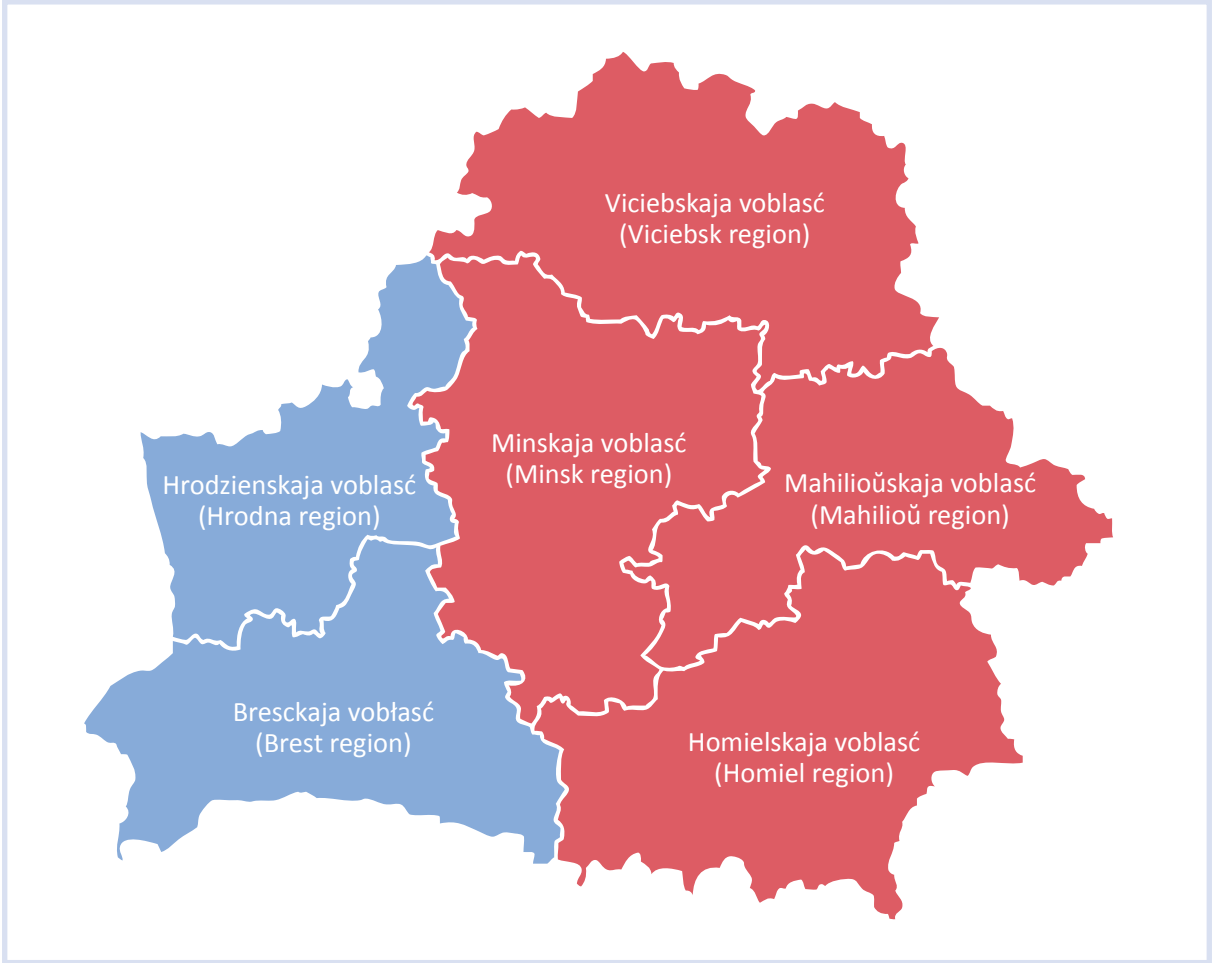



Figure 1. Regions of the Republic of Belarus with the highest level of migration (highlighted in red)

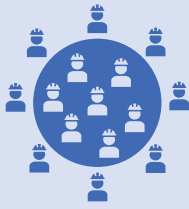
This map is for illustration purposes. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by International Organization for Migration (IOM).

1.4. Unsolved issues

A review of literature and interviews with key experts made it possible to identify existing barriers hampering the development of effective measures to reduce the number of HIV infections among migrants, namely:



Lack of reliable estimates as to the number of labour migrants, since some of the Belarusian citizens go to work abroad without obtaining relevant documents. On the other hand, some migrants from other countries work in Belarus without official permits.



Limited access to medical programs by migrants, because only a small number of organizations (for example, the Belarusian Red Cross Society) work with them and provide social services. Cooperation between government officials and organizations representing relevant diasporas in Belarus in many ways is still to be stepped up.



Incomplete information about places where migrants reside and work, which is related to a small number of studies conducted amongst this social group.



Unequal access of different categories of migrants to medical care, which is related to the conditions provided by bilateral treaties between Belarus and countries of origin, that serve as the framework for providing such assistance. In general, the legal regulation of issues related to providing medical care to foreign citizens needs to be improved.

CHAPTER 2. METHODOLOGY

2.1. Data collection method

The study, conducted from December 2017 to May 2018, consisted of several methods for collecting baseline data, including (1) a review of available documents on migration and HIV, (2) interviews with key experts, (3) a survey among migrants, and (4) focus groups with main categories of migrants in Belarus to refine the results of the survey. During the development of the research methodology, a number of documents were analysed by experts in coordination with UNAIDS and IOM Missions in Belarus, as well as with representatives of the Belarusian Ministry of Health. Among these documents, special attention was given to regulatory documents governing access to HIV diagnosis and treatment; statistical surveys on HIV and migration; national reports on the progress in the global AIDS response; analytical notes on the HIV response in Belarus; and scientific publications.

Key experts for conducting interviews were selected considering their participation in the regulation of migration issues, as well as in providing medical or social assistance to HIV-infected persons. Interviews with them, as well as focus groups, were conducted on a voluntary basis using a semi-structured questionnaire, various versions of which were prepared with regard to experts representing government agencies, medical services, international organizations, NGOs, and migrants themselves.

2.2. The sample population of the study

The study was conducted in the areas with a high migration rate as indicated in the statistical summary of the Ministry of Interior shared with authors in November 2017: Vitebsk, Gomel, Minsk regions and the city of Minsk. Gomel and Minsk regions as well as the city of Minsk, are also territories with high HIV prevalence, unlike Vitebsk region. Thus, the study included migrants from regions with different epidemiological profiles.

The selection of territories for inclusion in the study was based on the number of registered migrants per district in the selected regions and the city of Minsk. The selection was made with a probability proportional to the number of registered migrants. As a result, the cities of Vitebsk and Orsha were selected for Vitebsk region; Gomel and Svetlogorsk for Gomel region; and the city of Minsk and Minsk district for Minsk region.

The target groups of the study were the following:

- Persons travelling to work outside of the Republic of Belarus (international drivers);
- International students studying at higher educational institutions of the Republic of Belarus;
- Migrants living and working in the Republic of Belarus;
- Officials and medical specialists involved in the regulation and provision of medical assistance to migrants (key experts).

2.2.1 Survey

The purpose of the survey was to study the main sources of information on HIV infection; awareness about HIV prevention, as well as behavioural risk (sexual behaviour, use of psychoactive drugs); the level of awareness about hepatitis C and sexually transmitted infections (STIs) among the three target groups of migrants. Data were collected through a self-completed questionnaire; interviewers were trained on where to locate potential respondents, how to introduce the survey's objectives and to explain the way the questionnaire is to be completed.

Target groups:



A. *Persons travelling to work outside of the Republic of Belarus* (international drivers)

The total sample size is 272 respondents. Access to international drivers was provided through drivers' training courses at "BAMAP-VEDY" – the training centre of the Republican Association of International Road Carriers "BAMAP". Consistent with the research objectives, the survey was conducted in Minsk, Vitebsk and Gomel. Every driver who attended these courses between February and April 2018 was offered a self-completed questionnaire. No refusals to respond were registered.



B. *International students studying at higher educational institutions of the Republic of Belarus*

The total sample size is 351 respondents. The survey was conducted in Minsk, Vitebsk and Gomel. Three universities in Minsk, two universities in Vitebsk and two universities in Gomel were included in the sample. The number of respondents in each city and each university was selected proportionally to the number of international students in every city and university (178 in Minsk, 95 in Vitebsk, and 78 in Gomel). Interviews with the specified number of respondents (international students) were conducted at university dormitories where students resided.



C. *Migrants living and working in the Republic of Belarus*

The total sample size is 326 respondents. The survey was conducted in Minsk, Vitebsk, Gomel and Svetlogorsk. The number of respondents in each city was selected proportionally to the size of the population of foreign citizens in the cities mentioned above (179 people in Minsk, 65 in Vitebsk, 68 in Gomel, and 14 in Svetlogorsk). Interviews with the specified number of respondents were conducted at the regional branches of the Belarusian Red Cross Society (BRCS). Respondents were picked by way of interviewing all persons who requested assistance from BRCS between March and May 2018.

2.2.2. Focus groups and interviews

Organizations providing services to the above-mentioned target groups in the Republic of Belarus selected focus group participants inviting them to participate in the discussion:

- International drivers were invited via the Private Educational Institution “Centre for Advanced Training of Leaders and Specialists “BAMAP-VEDY”;
- International students were invited via the staff of university dormitories in Minsk and Gomel;
- Labour migrants were invited via the staff of the Belarusian Red Cross Society in Minsk and Gomel.

Focus groups were conducted between 4 and 10 May 2018. All participants gave informed verbal consent to participate in the focus group and to the audiotaping of the discussions.

Within the framework of the study, 15 individual interviews were conducted with specialists from the Citizenship and Migration Department of the Ministry of Internal Affairs; medical specialists from health facilities at the national level and in Gomel region; and representatives of international organizations, non-governmental and non-profit organizations providing services to migrants, including prevention, care and support related to HIV.

2.3. Limitations of the study

A preliminary analysis of the migration situation showed that the migrant population is not homogeneous and includes different groups, varying among other things, in their accessibility for research. Since this study is the first of its kind in the Republic of Belarus and has an exploratory character, it was focused on those groups, to which access was provided through existing organizational structures that expressed willingness to cooperate with the research team. Therefore, those categories of migrants with compact locations (at the place of study, work, or contact with non-governmental organizations) and the possibility to gather in a group for conducting interviews were included into the sampling population of the survey. Thus, international drivers were involved into the study as outgoing labour migrants, while foreign university students entering the Republic of Belarus and foreign citizens applying to the regional branches of the Belarusian Red Cross for various types of social assistance were treated as incoming migrants.

2.4. Ethical considerations

The study was approved by the Advisory Council for HIV/AIDS Monitoring and Evaluation of the Republic of Belarus⁴ and included in the plan for monitoring and evaluation of HIV/AIDS in the Republic of Belarus for 2018 (minutes of the meeting No. 25 of 27 March 2018).

During data collection activities, respondents were informed that their participation in the study was voluntary and anonymous and that all data would be reflected in the report in an aggregated form. To ensure the respondents’ anonymity in completing questionnaires, the following measures were taken:

⁴ The national monitoring system functions on the basis of interagency cooperation and is coordinated by the Advisory Council on Monitoring and Evaluation, which includes representatives of key ministries, non-profit and international organizations, as well as people living with HIV.

- Respondents were not required to provide any personal data such as their names, patronymics, passport data, residential addresses and places of work;
- Close-ended questions were used, where respondents were asked to choose from a list of pre-defined responses rather than provide a handwritten response;
- Participants were motivated to fill out the questionnaire in full, but they were informed that if they did not want to answer some questions, they could skip those;
- Processing and analysis of survey data were conducted by a specialist who was not involved in the data collection process.

To ensure comparability of research results with studies among other vulnerable groups, the standard wording of questions was used, and their acceptability for respondents was tested during a pilot survey.

To ensure the completeness of data during aggregation and analysis, focus groups were audio-recorded, and verbal informed consent was obtained from all focus group participants without exception. To ensure anonymity, the following measures were taken during interviewing:

- Participants were not required to provide any personal data such as their names, patronymics, passport data, residential addresses and places of work;
- Participants were not required to present themselves when answering a question;
- Participants were asked to answer all questions, but they were informed that if they did not want to answer some questions, they could skip those.

CHAPTER 3. RESULTS OF THE QUANTITATIVE AND QUALITATIVE RESEARCH

LEGEND

One icon means approximately 5%



Persons travelling to work outside of the Republic of Belarus (international drivers)



International students studying at higher educational institutions of the Republic of Belarus



Migrants living and working in the Republic of Belarus

Hatched icons are used for small values (< 2,5%)

10 %
5 pers.

Exact numbers are specified below

3.1. Results of the survey of persons who leave to work outside Belarus (international drivers)

International drivers selected in the sample are males between 30 and 44 years of age (49%), with secondary and above education (91%). Most of them are married (70%) and reside in urban areas (84%). They tend to be financially secure, with three-quarters of respondents considering their material conditions “average” or “above average” (for details see Annex 3).

SUMMARY

1. **International drivers’ knowledge of the ways of HIV transmission is not comprehensive, but the majority know the main ways of HIV transmission.** Only 28.7 per cent answered all questions about the routes of HIV transmission correctly. However, they are familiar with the modes of transmission: 84.6 per cent know that the use of condom reduces the risk of HIV infection, 94.9 per cent know that it is possible to become infected with HIV when sharing syringes or needles during intravenous drug use; and 85.7 per cent know that HIV can be transmitted while getting a tattoo, a manicure or shaving with non-sterile instruments.

At the same time, only 78.2 per cent of the interviewed drivers answered the question “Can a healthy-looking person have HIV?” correctly. Also, not all respondents know how HIV is *not* transmitted. Thus, only 48.5 per cent of respondents know that HIV is not transmitted through a mosquito bite; 62.1 per cent know that HIV is not transmitted via usual household contacts with an HIV-positive person (using a shared bath, a pool or a toilet).

2. **The overall knowledge of international drivers on the stages of the disease and the test window is not comprehensive.** Less than half of the respondents (43%) know that AIDS is the last stage of HIV infection. More than a quarter of respondents (29.8%) believe that HIV infection and AIDS are the same diseases; 8.5 per cent consider HIV and AIDS to be two different diseases, and 18.8 per cent of respondents found it difficult to answer this question. Concerning the HIV test window period, only 25.7 per cent of respondents know that HIV infection is detected in blood only three months after infection, and 58.8 per cent found it difficult to answer this question.
3. **The majority of international drivers (92.3%) received information about HIV infection from various sources, mostly from mainstream sources such as television programmes (63.3% of those who received information about HIV/AIDS) and out-of-home advertising (55%).** Other sources of information are less common: 33.9 per cent of respondents received information from the Internet; 31.5 per cent from special literature, leaflets, booklets; 23.1 per cent from medical personnel; and 20.7 per cent during their study at the university. It should be noted that only 10 per cent of respondents received HIV information from lectures and classes at work. As the drivers received information about HIV mostly from mainstream sources, it can be assumed that the information is very general, not adapted to the behavioural specifics of this target group.

Geographically, 68.9 per cent of respondents (*of those who received information about HIV/AIDS*) received information about HIV mainly in Belarus; 22.3 per cent both in Belarus and in another country, 4.8 per cent mainly in another country.

4. **Awareness of sexually transmitted infections among international drivers is very high, and one in four drivers had been tested recently.** More than 90 per cent are aware of sexually transmitted infections, only 6.3 per cent of respondents said that they did not know about such infections, and 2.9 per cent failed to answer this question. More than one fourth (26.1%) had been tested for sexually transmitted infections (syphilis, gonorrhoea, herpes, chlamydia, and others) over the last six months. Concerning prevention, the majority 79.8 per cent of respondents (*who reported being aware about the STIs*) believed that it was possible to avoid STIs during sexual intercourse with a non-regular partner by always using a condom, while 16.2 per cent noted that treating reproductive organs with disinfectants (miramistin, chlorhexidine) after unprotected sexual intercourse would make it possible to avoid infection.
5. **Awareness of hepatitis C is moderate among international drivers, knowledge of transmission modes is low, and only 6.3 per cent got tested recently.** Sixty-nine per cent of drivers are aware of the existence of hepatitis C, while more than a quarter (26.1%) does not know this infection, and 5.1 per cent did not provide an answer. Over the last 6 months, 9.1 per cent of respondents (*those who were aware of the existence of hepatitis C*) have been tested for hepatitis C, which is 6.3 per cent of the total number of respondents.

Less than a quarter (23.3%) correctly named all the existing ways of transmission. Only 66.8 per cent know that hepatitis C is transmitted through sharing instruments (syringes, needles, and others) used to inject drugs; 52.4 per cent that hepatitis C can be transmitted while getting a tattoo, a manicure or shaving with non-sterile instruments; and 49.2 per cent during sexual intercourse without a condom. Some falsely believe that hepatitis is transmitted by airborne droplets (10.2%); when eating with dirty hands (5.9%); or through a mosquito bite (6.4% *of those who were aware of the existence of hepatitis C*).

6. **Less than half of the respondents (46.3%) used a condom with the last non-regular sexual partner, mainly out of trusting the person.** More than one 27.7 per cent of respondents had sexual contacts with a non-regular sexual partner over the last 12 months, with 58.2 reporting having had more than one partner, with an average of two partners (median number). Forty-six per cent of respondents used a condom during the last contact with a non-regular partner. At the same time, 37.3 per cent of respondents reported to always use a condom with a non-regular sexual partner. These values indicate that the level of the target group's behavioural sexual risk in contacts with non-regular partners as very high. The main reason for not using a condom was "When I trust a partner" (42.6%). Also common were such reasons as "I do not use it if I think that my partner is healthy" (22.2%), "Condom reduces sexual pleasure" (18.5%), "I'm not used to it" (16.7%) and "Condoms are not always available when needed" (14.8%). Thus, most reasons for not using a condom were not beyond respondents' control (there was no possibility to buy a condom), but rather internal (existing habits, stereotypes, and others).
7. **The majority (86.4%) has a regular sexual partner, and 18.6 per cent (45 persons) had sex with both regular and non-regular partners during the last 12 months.** 40 per cent of the latter had used a condom during their last sexual contact with a non-regular partner. Among those who had sexual contacts with both regular and non-regular partners over the past 12 months, 31.1 per cent claimed to have always used a condom with a non-regular sexual partner. Thus, regular partners of those respondents who also had non-regular partners are, along with respondents, are at risk of being infected with HIV.
8. **Only a few respondents (7.4%) reported purchasing sexual services, with less than half of them using a condom the last time.** At the same time, 13.2 per cent of respondents did not answer this question. Eight respondents out of 18 (44.4%) used condoms during the last sexual contact when buying sexual services. Out of the respondents with regular partners, 7.2 per cent purchased sexual services over the last 12 months. Of these, 6 respondents out of 15 (40%) used condoms during the last sexual contact when buying sexual services. Thus, the level of sexual risk in commercial sex is high and requires further in-depth study.

Engagement in transactional sex was only reported by two persons (0.8% of those who had had sexual intercourse over the last 12 months). They did not use condoms during the last transactional sex contact.

9. **The assessment of the personal risk of HIV infection among drivers is ambiguous, splitting them about half-half.** More than a quarter (26.8%) of respondents believe that they are at risk of HIV infection (16.9% said "yes", 9.9% "more likely 'yes' than 'no'"), while almost half (48.5%) believe that there is no such a risk in their lives (31.6%) or "more likely 'no' than 'yes'" (16.9%). However, 21 per cent of respondents found it difficult to answer this question, and 3.7 per cent did not answer at all.

There is a strong correlation ($P < 0.05$) between the estimated personal risk of HIV infection and getting STI tests over the last 6 months. Respondents who were tested for STIs assessed that the risk of HIV infection was higher for them personally than for those who did not get such tests: "yes" and "more likely 'yes' than 'no'", with 37.6 per cent and 24 per cent respectively. No differences were identified in the assessment of HIV infection risk by the age of respondents, as well as regarding knowledge about HIV infection, and as behavioural characteristics (having a non-regular sexual partner).

10. **While consumption of alcohol is common among this group, less than one per cent ever injected drugs.** Seventy-four per cent of respondents consumed alcohol during the last month. Most common were strong spirits (vodka, cognac, whisky, moonshine), which were consumed by 60.7 per cent of respondents who drank alcohol during the last month. Almost half (48.8%) consumed beer, while consumption of wine (14.4%) and low-alcohol drinks (4.5%) were low. Seven per cent of respondents noted that they ever took non-injecting drugs (smoking mixtures, “grass”, tablets, solutions, powder). Only 0.8 per cent of respondents indicated that they had ever injected drugs (once or several times) and 4.4 per cent of respondents did not answer this question (“I do not want to answer this question” and “No answer”).

11. **Although about three-quarter of the international drivers are aware of HIV testing options, only one in ten got tested for HIV recently.** Seventy-three per cent of respondents said they could currently get tested for HIV, while 7.7 per cent of respondents believe they could not; 14.7 per cent did not know, and 4 per cent did not answer the question. Forty per cent of respondents had ever been tested for HIV infection, with 91.7 per cent of them knowing the test results. Of those, 23.9 per cent of respondents have been tested for HIV over the past 12 months. In aggregate, 9.6 per cent of respondents got tested for HIV over the past 6 months. The share of respondents who have been tested for HIV infection within the last 6 months and knew their result was 7 per cent of all respondents. At the same time, the experience of taking HIV tests did not significantly affect the level of knowledge of those tested on HIV issues.

3.1.1. HIV infection awareness

Less than half of international drivers (43%) **know that AIDS is the last stage of HIV infection**. More than a quarter of respondents (29.8%) believe that HIV infection and AIDS are the same diseases; 8.5 per cent consider HIV and AIDS to be two different diseases; while 18.8 per cent of did not know how to answer this question (Figure 2).

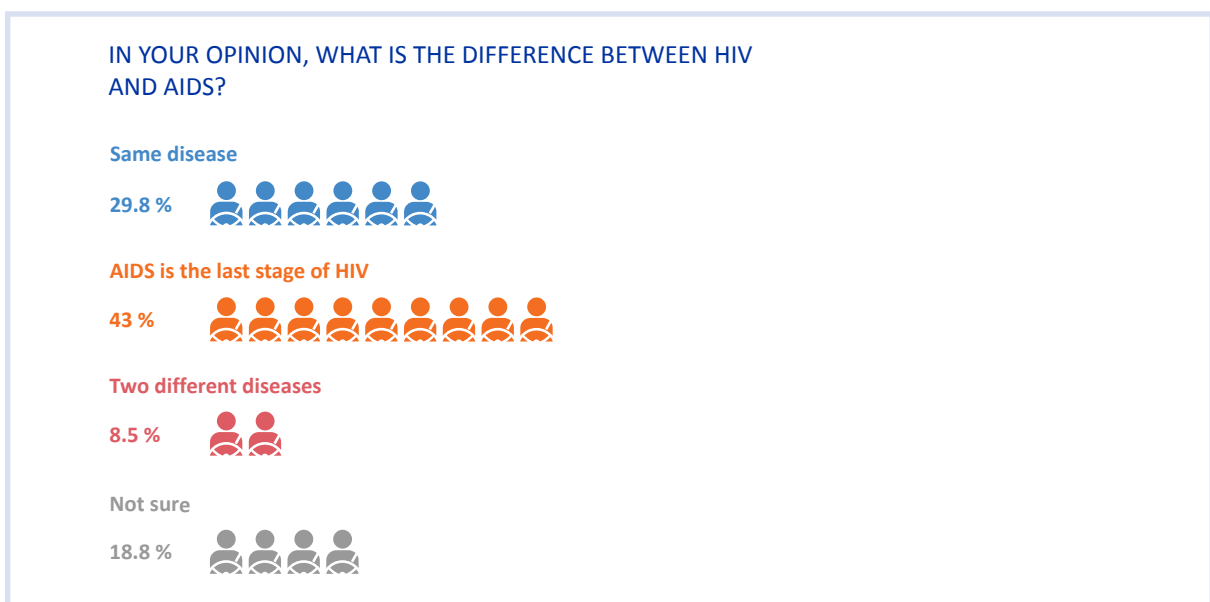


Figure 2. Percentage distribution of the international drivers’s responses whether HIV is different from AIDS

Respondents' awareness of HIV tests window period is also low. Only 25.7 per cent of respondents know that an HIV infection can be detected in blood only three months after infection, and 58.8 per cent failed to answer this question (Figure 3).

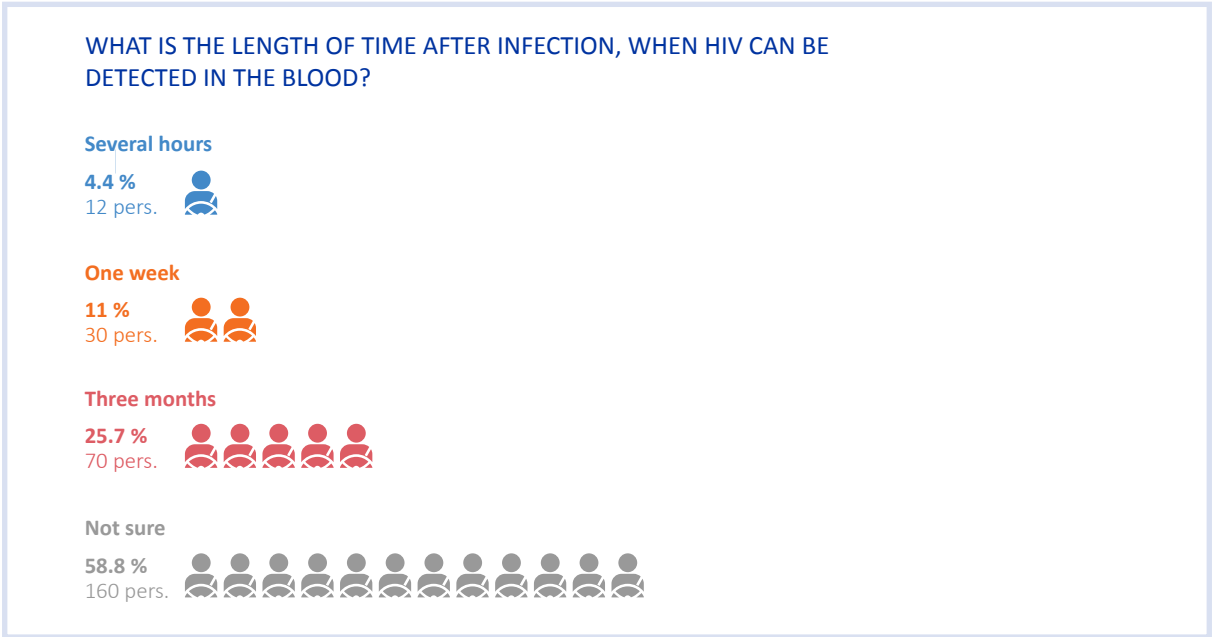


Figure 3. Percentage distribution of the international drivers' responses to the question of when HIV can be detected in the blood

Sixty-five per cent of respondents believe that an HIV-positive person could maintain good health for many years, provided they receive special drugs (antiretroviral therapy), while 31.6 per cent of the drivers were "not sure" of their answer this question (Figure 4).



Figure 4. Distribution of international drivers' answers to the question on the health condition of PLHIV

The majority of respondents know the main routes of HIV transmission. The level of awareness about existing modes for HIV transmission was highest with regards to the question "Can one be infected with HIV by sharing instruments (syringes, needles, etc.) during the intravenous drug use?" (94.9% of drivers gave correct answers), and lowest with regards to the question "Can a healthy-looking person have HIV?" (78.3% answered correctly).

At the same time, the level of knowledge about **non-existent** HIV transmission modes is limited:

- Only 48.5 per cent of respondents know that HIV is not transmitted through a mosquito bite; 19.9 per cent believe that one could be infected with HIV in this way; almost a third of respondents (31.6%) failed to answer the question.
- Sixty-two per cent of respondents know that HIV is not transmitted through household contacts (when using a shared bath, a pool or a toilet with an HIV-infected person); 12.5 per cent believe that one could be infected with HIV in this way; and a quarter of respondents (25.4%) failed to answer this question (Figure 5).



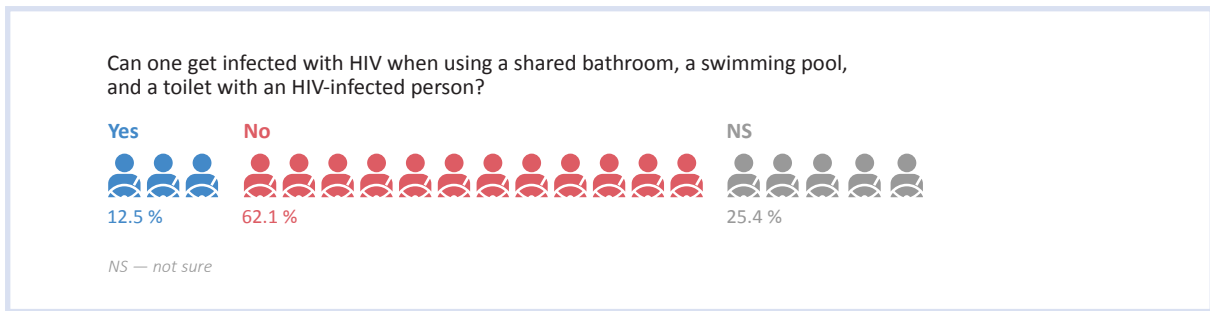


Figure 5. Knowledge of international drivers regarding HIV transmission

In general, 34.9 per cent of respondents demonstrated a correct understanding of the ways of preventing HIV sexual transmission and at the same time rejected main misconceptions related to HIV transmission (for the 5 questions below):

- “Can the risk of HIV transmission be reduced if a person has only one faithful uninfected partner?”
- “Can the risk of HIV transmission be reduced by using condoms?”
- “Can a healthy-looking person have HIV?”
- “Can one get infected with HIV through a handshake?”
- “Can one get infected with HIV through a mosquito bite?”

Twenty-nine per cent of respondents answered all the questions about modes of HIV transmission correctly; while 92.3 per cent of the respondents received information about HIV/AIDS from various sources. At the same time, 5.1 per cent of respondents noted that they did not receive any information; 2.6 per cent of respondents did not answer the question.

The main sources of information on HIV/AIDS for drivers were television programmes and advertising – those sources were mentioned by 63.3 per cent of respondents (of those who did receive information about HIV/AIDS). Other common sources of information were public awareness campaigns and advertising (55%). Thirty-four per cent of respondents received information on the Internet, 31.5 per cent from special literature, leaflets and booklets. Twenty-three per cent of respondents received such information from medical personnel; 20.7 per cent during their studies at university. Only 10 per cent of respondents received information about HIV at lectures and classes at work (Figure 6).

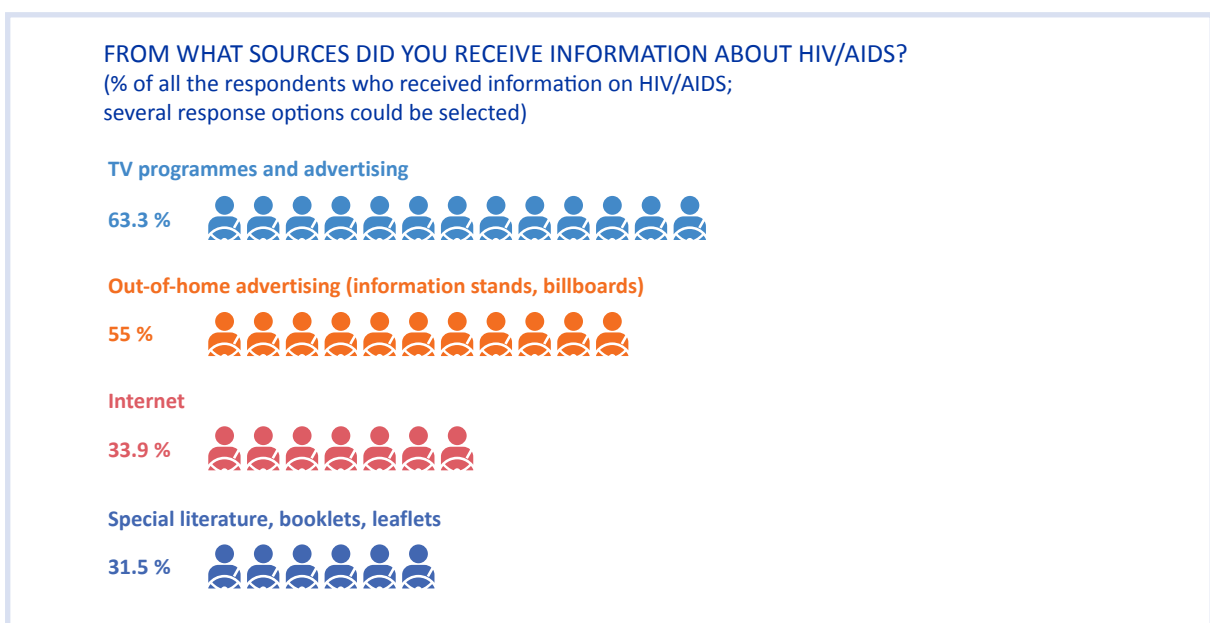




Figure 6. Sources of information about HIV/AIDS among international drivers (% of all the respondents who received information on HIV/AIDS; several response options could be selected)

Thus, 91.2 per cent of drivers received information about HIV in Belarus. Sixty-nine per cent (*out of those respondents who received information about HIV/AIDS*) received information about HIV mainly in Belarus; 22.3 per cent both in Belarus and in another country, 4.8 per cent in another country (Figure 7).

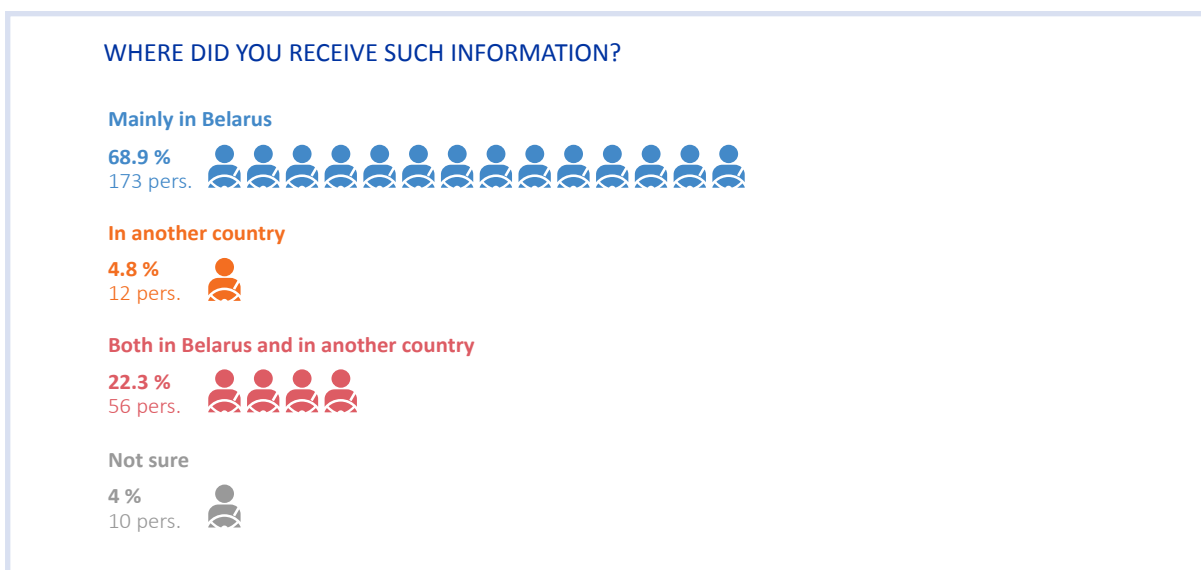


Figure 7. Distribution of international drivers according to where they received information about HIV

3.1.2. Awareness about sexually transmitted infections (STIs)

The majority (90.8%) of drivers are aware of sexually transmitted infections, 6.3 per cent noted that they did not know about such infections, and 2.9 per cent did not answer this question (Figure 8).

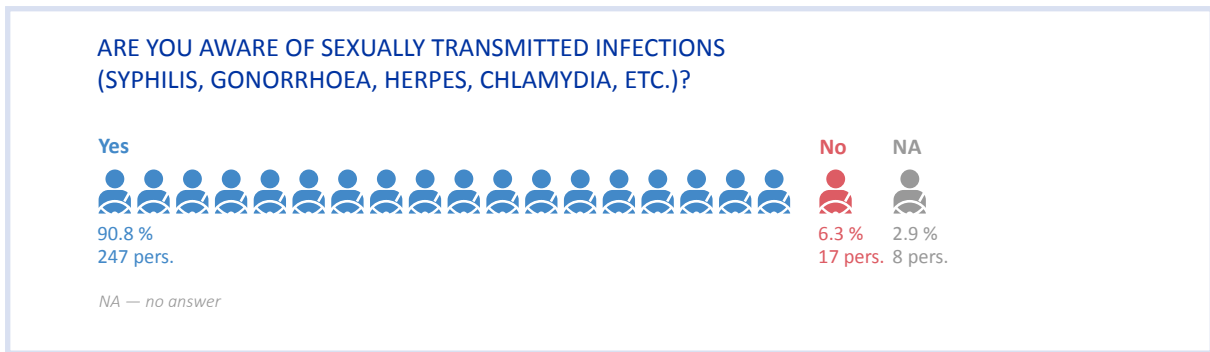


Figure 8. Distribution of international drivers according to awareness of sexually transmitted diseases

Twenty-nine per cent of respondents (out of those who know about STIs) had been tested for sexually transmitted infections (syphilis, gonorrhoea, herpes, chlamydia, etc.) in the past six months (Figure 9).

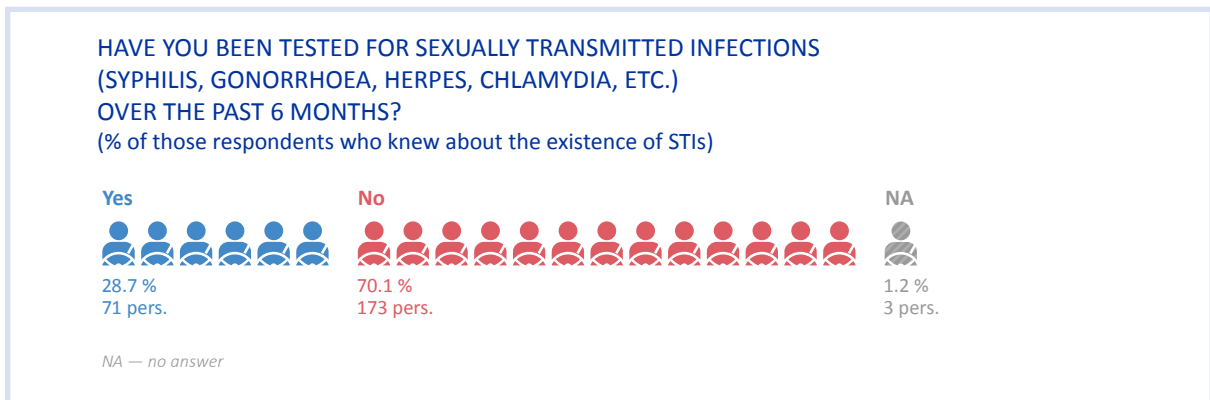
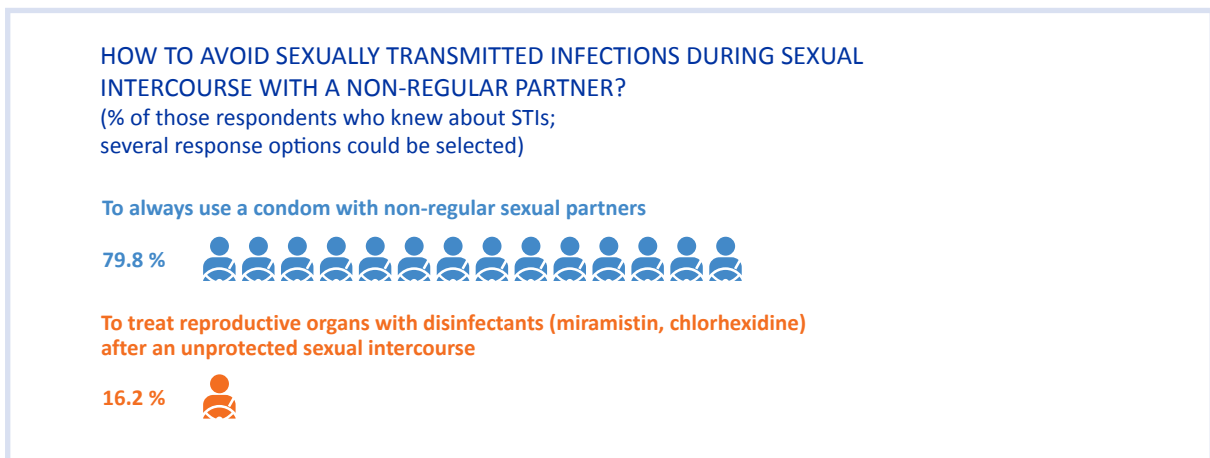


Figure 9. Distribution of international drivers according to past medical history of having been tested for sexually transmitted diseases over the past 6 months

Out of the total number of those interviewed, 26.1 per cent were tested for sexually transmitted infections over the past six months. The majority (79.8% out of those who knew about the existence of STIs) believe that it is possible to avoid being infected with STIs during sexual intercourse with a non-regular partner if you always used a condom. 16.2 per cent believe that treating reproductive organs with disinfectants (miramistin, chlorhexidine) after unprotected sexual intercourse makes it possible to avoid infection (Figure 10).



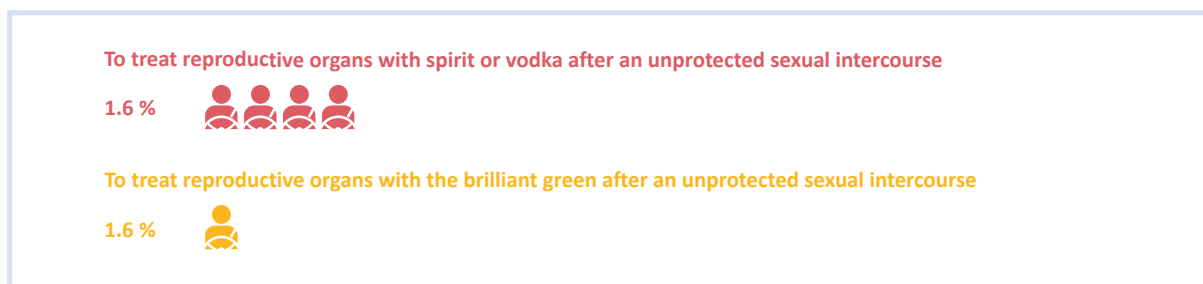


Figure 10. Methods to avoid sexually transmitted infections listed by respondents

3.1.3. Awareness about hepatitis

Sixty-nine per cent of the drivers surveyed are aware of the existence of hepatitis C, while 26.1 per cent do not know about such infection, and 5.1 per cent failed to answer the question (Figure 11).

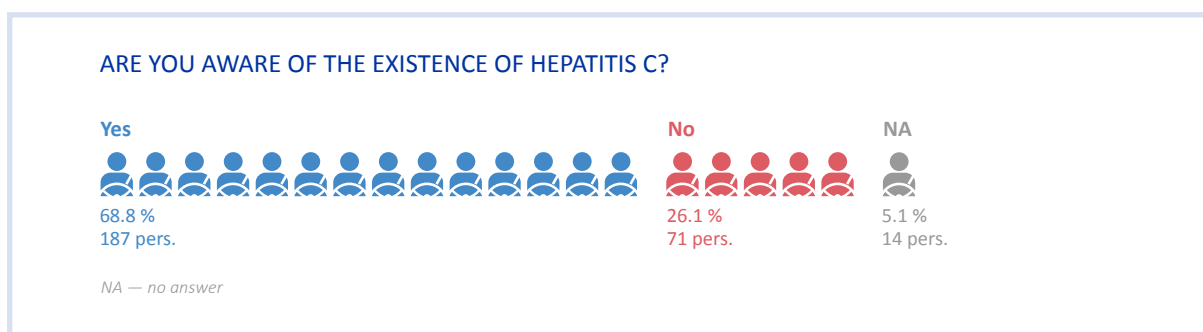


Figure 11. Distribution of international drivers according to awareness of hepatitis C

Six per cent of the total number of respondents have been tested for hepatitis C over the past six months. 9.1 per cent respondents were tested for hepatitis C over the past six months (of those respondents who knew about hepatitis C) (Figure 12).

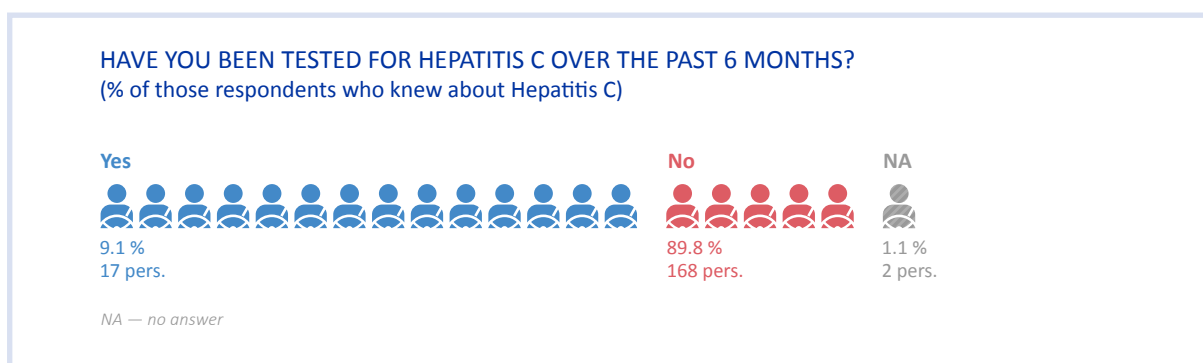


Figure 12. Distribution of international drivers according to past medical history of having been tested for hepatitis C in the past 6 months

The level of respondents' knowledge about the ways of transmission of hepatitis C is low. In general, 16.9 per cent of all the drivers interviewed correctly named all the existing ways of transmission of hepatitis C. Thus, when listing the ways hepatitis C is transmitted:

- 66.8 per cent of respondents know that hepatitis C could be transmitted by shared use of instruments (syringes, needles, etc.) when injecting a drug with a syringe (of those respondents who knew about the existence of hepatitis C);

- 52.4 per cent know that hepatitis C can be transmitted during tattooing, manicure or shaving with non-sterile instruments;
- 49.2 per cent know that hepatitis C can be transmitted through sexual intercourse without a condom.

At the same time, non-existent ways of hepatitis C transmission were also mentioned:

- 10.2 per cent of the respondents believe that hepatitis C is spread via airborne transmission;
- 5.9 per cent by eating with dirty hands;
- 6.4 per cent with mosquito bites (Figure 13).

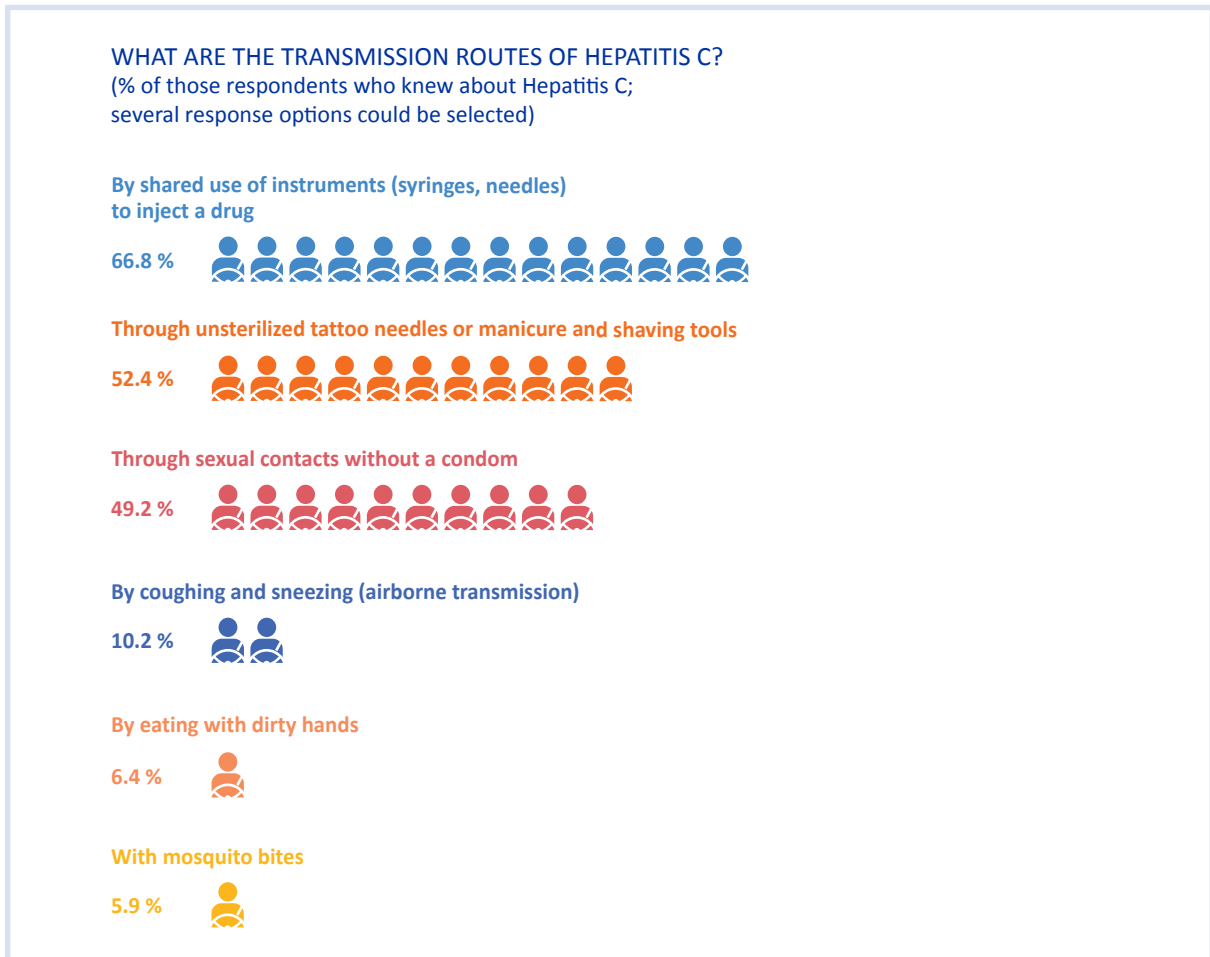


Figure 13. Awareness of international drivers as to the transmission routes of hepatitis C

3.1.4. Sexual behavioural risk

Ninety two and three per cent of respondents reported ever having sexual contact. Ninety-six per cent of those who reported ever having sexual contacts (or 89% of all respondents) had sex over the past 12 months.⁵

Twenty-eight per cent of respondents had sex with a non-regular sexual partner over the last 12 months (Figure 14).

⁵ The figures provided further in this section are calculated for respondents who reported ever having sexual contacts and had sex over the last 12 months.



Figure 14. Distribution of international drivers according to history of having a sexual intercourse with a non-regular partner over the last 12 months

Fifty-eight per cent of respondents who had a non-regular sexual partner over the last 12 months had contacts with more than one partner (Figure 15).

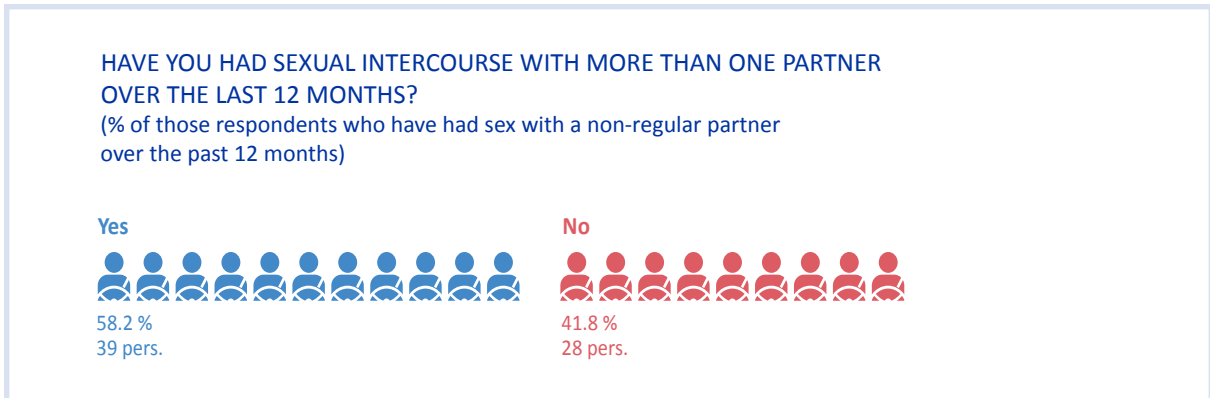


Figure 15. Distribution of international drivers according to history of having more than one sexual partner over the last 12 months

Those who reported having sex with more than one non-regular partner in the past 12 months, had two different sexual partners on average (median) over the past 12 months. Forty-six per cent of respondents who had sex with a non-regular partner used a condom during their last intercourse with a non-regular partner (Figure 16).

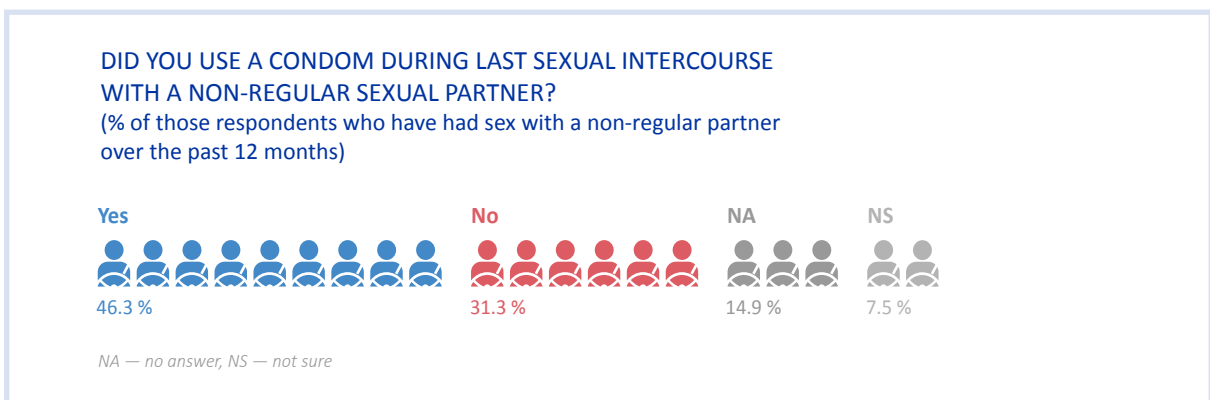


Figure 16. Condom usage among the international driver respondents during last sexual intercourse with non-regular sexual partner

Thirty-seven per cent of the respondents said they always use a condom with a non-regular sexual partner (Figure 17).

DO YOU USE CONDOMS DURING SEXUAL INTERCOURSE WITH A NON-REGULAR PARTNER(S)?
 (% of those respondents who have had sex with a non-regular partner over the past 12 months)

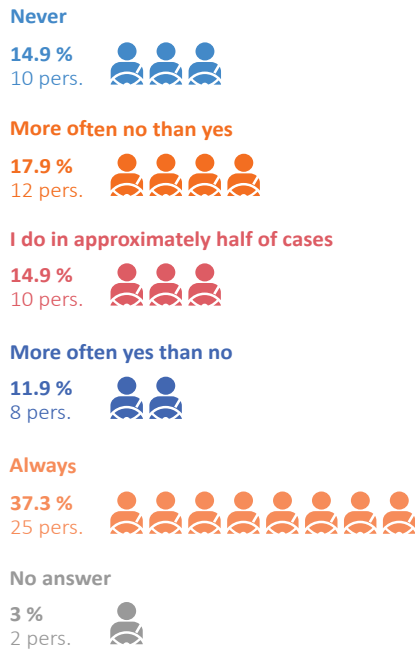


Figure 17. Frequency of using condoms with a non-regular partner as claimed by international drivers

The main reason for the respondents' non-use of a condom is "When I trust a partner" (42.6%). Also, the following reasons are common: "I do not use it if I think that my partner is healthy" (22.2%), "Condom reduces sexual pleasure" (18.5%), "I'm not used to this" (16.7%) and "Condoms are not always available when needed" (14.8%) (Figure 18).

IF YOU DO NOT USE A CONDOM DURING A SEXUAL INTERCOURSE WITH A NON-REGULAR PARTNER, THE REASONS ARE ...
 (% of those respondents who have had sex with a non-regular partner in the last 12 months; several response options could be selected)

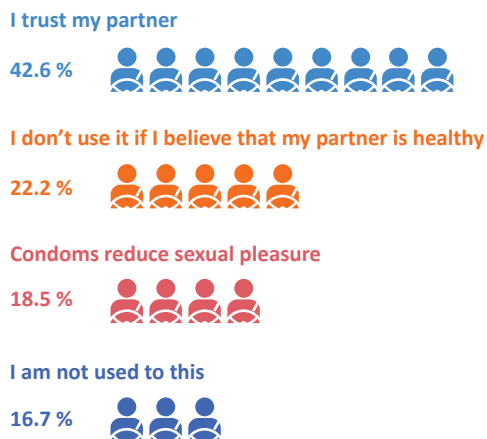




Figure 18. Reasons for not using a condom with a non-regular partner according to the international drivers

Eighty-six per cent of respondents have a regular sexual partner (Figure 19).

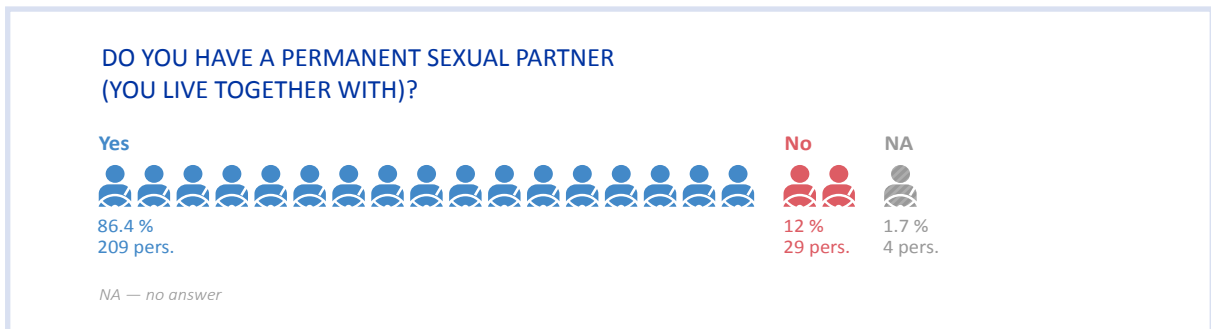


Figure 19. Availability of a permanent sexual partner among international drivers

Eighteen per cent of respondents (45 people) had sexual intercourse with both regular and non-regular partners over the last 12 months. Forty per cent of them used a condom during the last sexual intercourse with a non-regular partner (Figure 20).

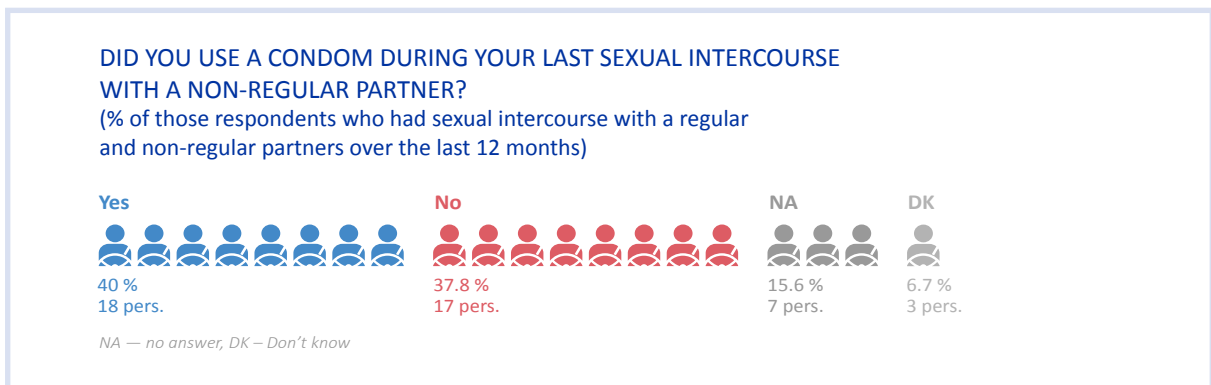


Figure 20. Condom usage during last sexual contact with a non-regular partner among the international drivers

Thirty one per cent of respondents who had sexual intercourse with regular and non-regular partners over the last 12 months always use a condom with a non-regular sexual partner (Figure 21).

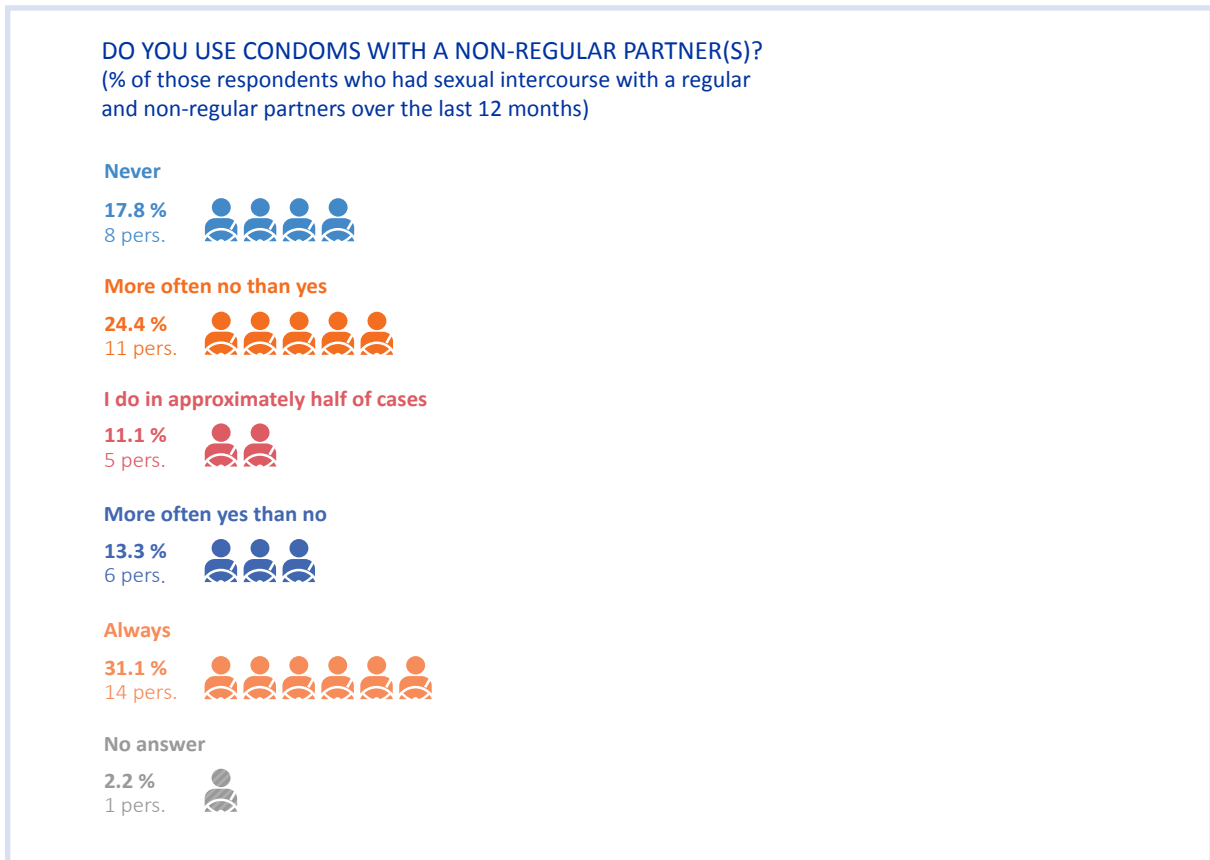


Figure 21. Frequency of using condoms with a non-regular partner among the international drivers

Less than one per cent of respondents, who had sexual intercourse over the last 12 months, reported having exchanged sex for remuneration. Three per cent of respondents did not answer this question (Figure 22).

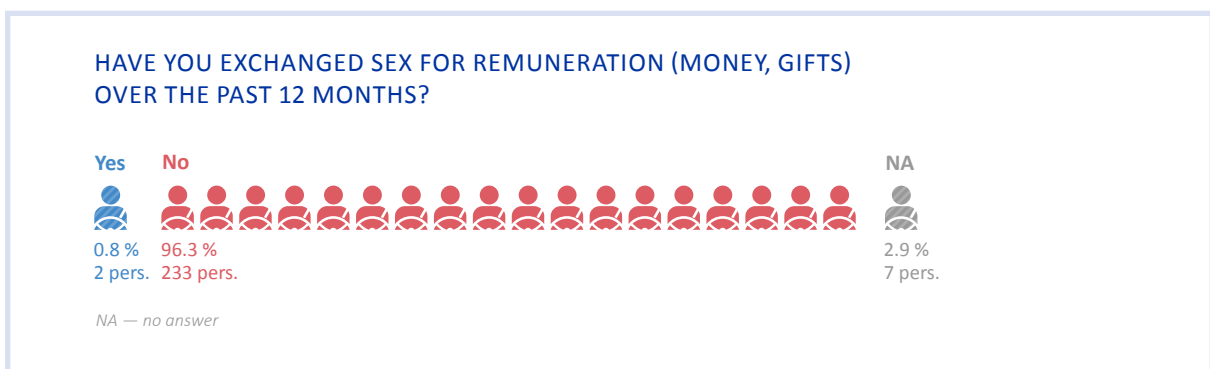


Figure 22. Distribution of international drivers according to claim of exchanging sex for remuneration over the past 12 months

Condoms were not used during the last transactional sexual intercourse. 7.4 per cent of those respondents, who had sexual intercourse over the last 12 months, purchased sexual services (remunerated their partner for sex). 13.2 per cent of respondents did not answer this question (Figure 23).



Figure 23. Distribution of international drivers according to claim of remunerating partner for sex over the last 12 months

3.1.5. Consumption of psychoactive substances

Seventy-four per cent of respondents consumed alcohol over the last month (30 days) (Figure 24).

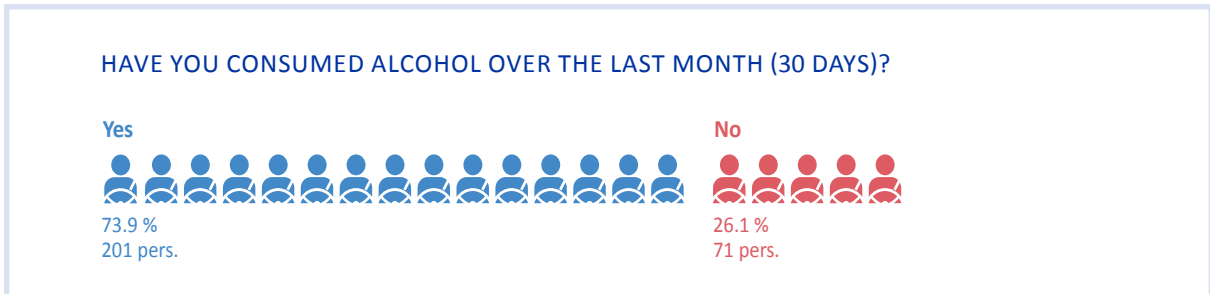


Figure 24. Distribution of international drivers according to history of having consumed alcohol over the last 30 days

Strong spirits (vodka, cognac, whisky and/or moonshine) were most commonly used alcoholic beverages – 60.7 per cent of all respondents who consumed alcohol over the last month (30 days) drank strong spirits. 48.8 per cent of respondents drank beer. Consumption of wine (14.4%) and low-alcohol beverages (4.5%) was less common (Figure 25).

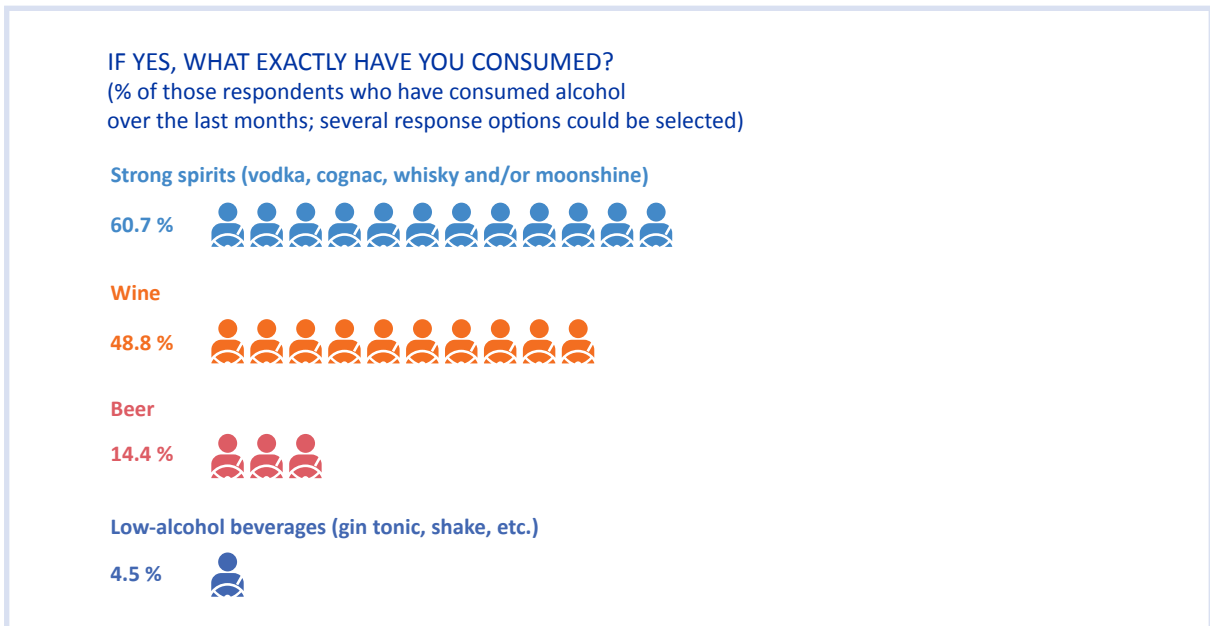


Figure 25. Alcohol preferences among international driver respondents

Seven per cent of international drivers reported having ever used non-injection drugs (smoking blends, “weed”, pills, solutions, powders) (Figure 26).

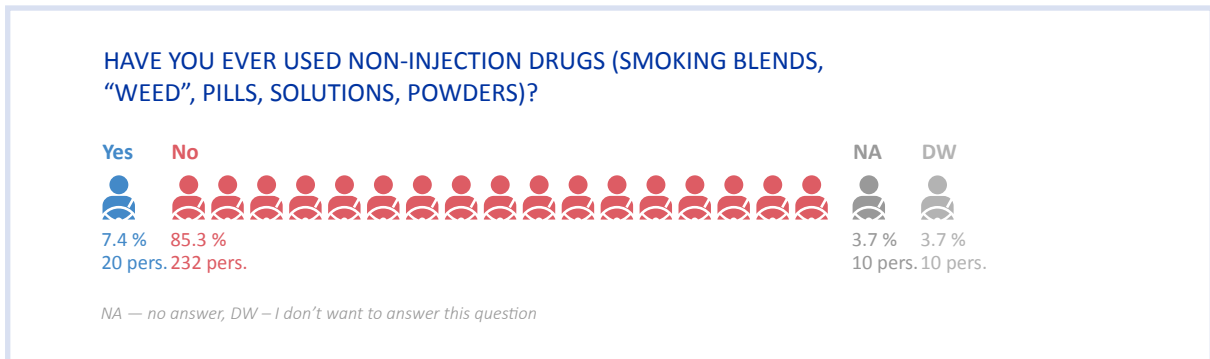


Figure 26. Distribution of international drivers according to history of ever-used non-injectable drugs

Less than one per cent of respondents said they had used injection drugs (once or several times). Four per cent of respondents did not answer this question (Figure 27).



Figure 27. Distribution of international drivers according to history of ever-used injectable drugs

3.1.6. HIV testing

More than a quarter (26.8%) of drivers believe there is a real risk for them to get infected with HIV (16.9% answered “yes”, 9.9% “more likely ‘yes’ than ‘no’”). Almost half (48.5%) of respondents believe that there is no such risk in their lives (31.6%) or that it is unlikely (16.9%). Twenty-one per cent of respondents found it difficult to answer this question, and 3.7 per cent failed to answer (Figure 28).



Figure 28. Perception of personal HIV risk among international driver respondents

There is a certain correlation ($P < 0.05$) between assessing the personal risk of HIV infection and getting an STI test over the last 6 months. Those who think they are at risk, are more likely to getting tested for STIs: “yes” and “more likely ‘yes’, than ‘no’” yielded 37.6 per cent and 24 per cent respectively (of those who answered the question) (Figure 29).

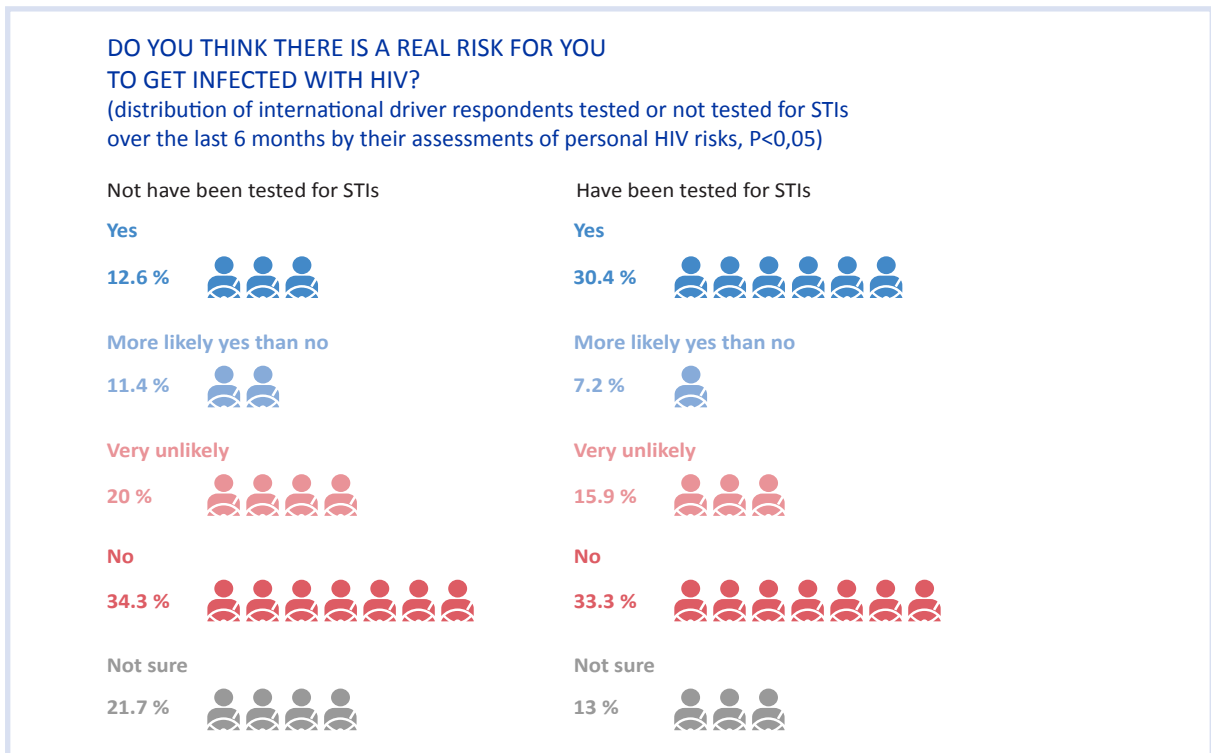


Figure 29. Distribution of international driver respondents tested or not tested for STIs by their assessments of personal HIV risks

No correlation was identified between the estimated risk of HIV infection and age, knowledge on HIV infection, and behavioural characteristics (having a non-regular sexual partner). Nearly one quarter of respondents think that they can get tested for HIV. 7.7 per cent of respondents believe that they cannot get tested currently; 14.7 per cent did not know, and 4 per cent did not answer this question (Figure 30).

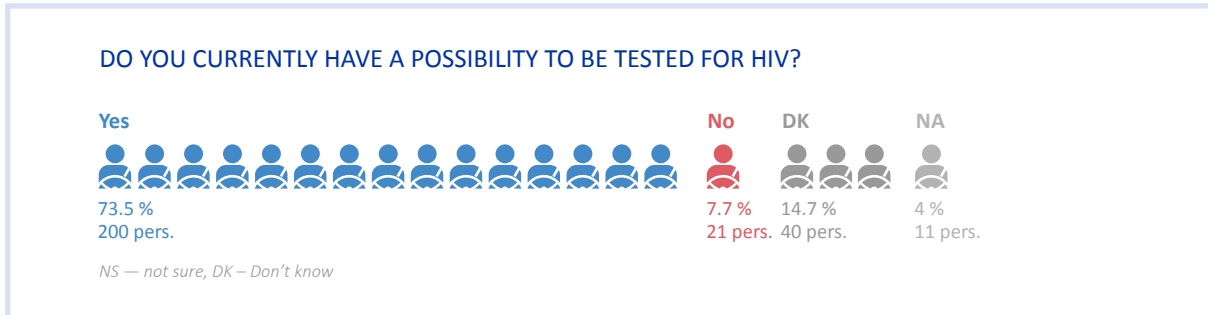


Figure 30. Distribution of international drivers according to the perceived opportunity for having HIV test available

Forty per cent of respondents have been tested for HIV, and 91.7 per cent know the results of their tests. Of these, 23.9 per cent of respondents have been tested for HIV infection in the last 6 months (Figure 31).

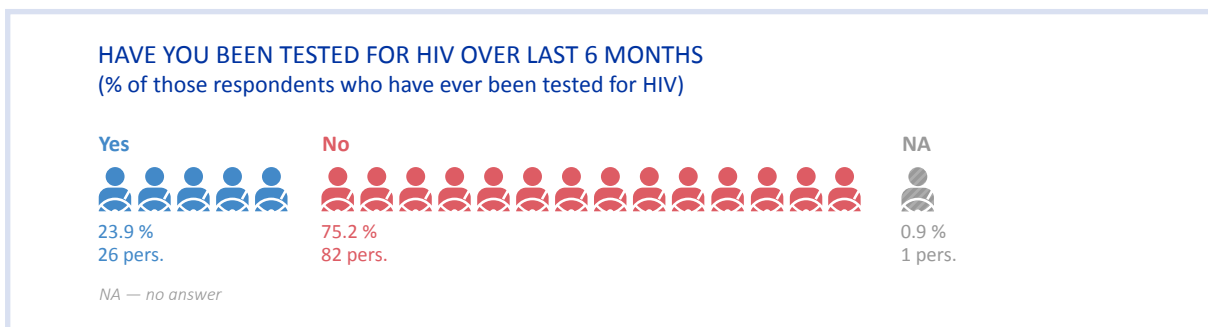
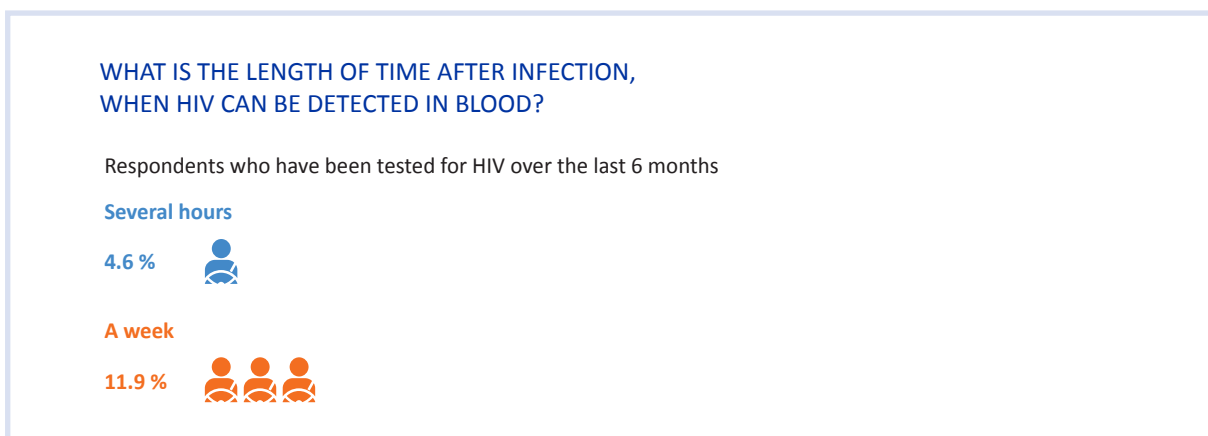


Figure 31. Distribution of international drivers according to history of having been tested for HIV over the last 6 months

There is a statistically significant difference ($P < 0.05$) as to the level of knowledge about the HIV test window and getting tested for HIV. 33.9 per cent of respondents who were tested for HIV, know that the virus is detected in the blood after 3 months. Among the respondents who never took the HIV test, the share is 20.3 per cent. However, the level of knowledge on this issue in both groups was not high (Figure 32).



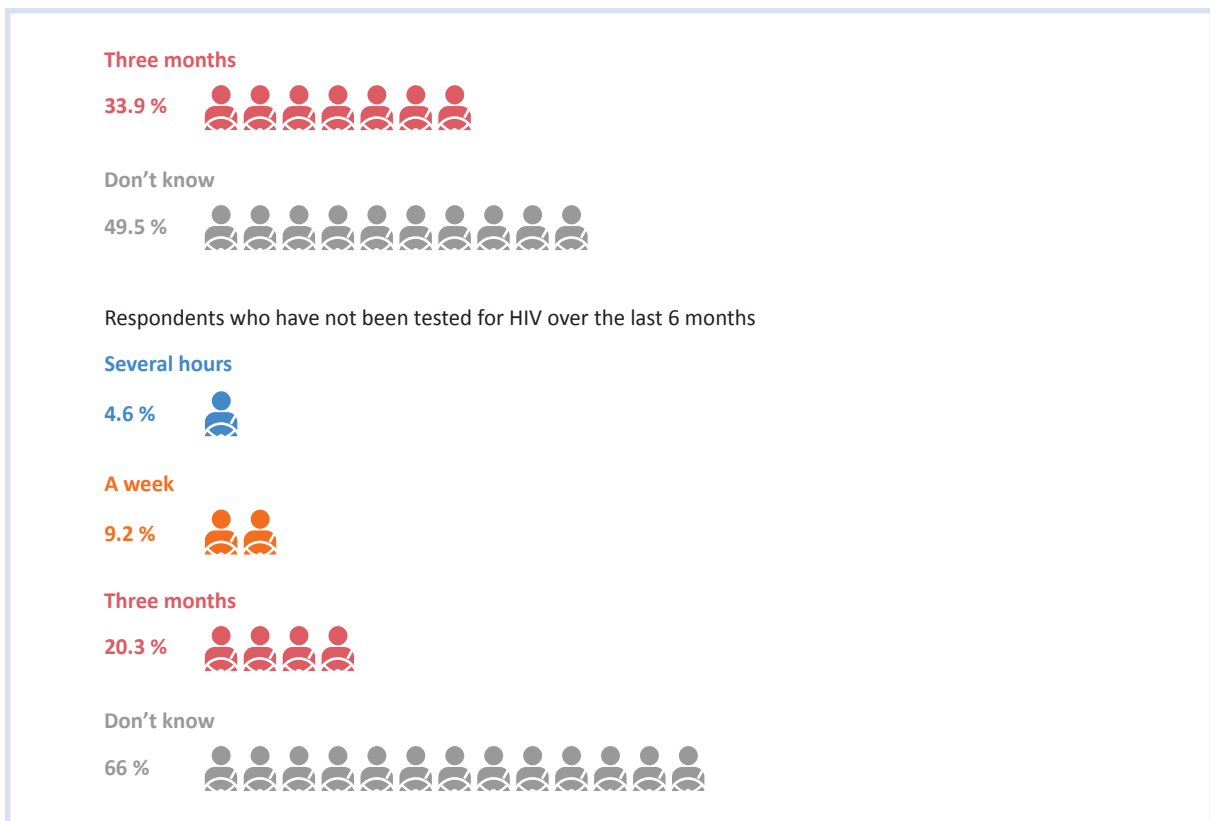


Figure 32. Awareness of when HIV can be detected among international drivers who have been tested and those who have not been tested for HIV

There was no difference in terms of knowledge of HIV transmission modes between respondents who have ever been tested for HIV, and those who have not. Thus, getting tested for HIV did not significantly affect tested persons level of knowledge.

3.2. Focus group results among persons who work outside Belarus (international drivers)

3.2.1. Sources of information about HIV, STIs and hepatitis C

Only two participants in the focus group discussion acknowledged that problems associated with HIV and sexually transmitted infections are relevant for them.

“Life is life, and no one is immune from risky situations. Anything can happen in life in general, therefore I admit that there is a chance this can happen to me.”

“Everything depends on a person, on his background, on his actions in this or that situation. Some people can control themselves and their behaviour, some people cannot.”

The rest considers HIV and STIs as irrelevant for themselves due to age, family values, and confidence in their partner.

“This is not relevant anymore at my age.”

“ My family is a value for me, I raised my children, they neither smoke nor drink, my wife and I are confident in each other. ”

“ There will be no casual contacts anymore in my life because there is a family, there are children, family is a value for me. ”

Sources of information about HIV, STIs and hepatitis C are mass [media](#), [posters and information stands in polyclinics and medical centres](#), where people can read the information while waiting for their appointment. Participants also mentioned information stands located on the Belarusian side of the border, [booklets](#) in the cafes along the road on the way to Lithuania and Latvia, and large [billboards](#) that can be read even in the dark located along the roads outside any regional centre on the way to the Russian Federation. However, when asked about specific information placed on such billboards, almost no one could remember anything.

“ I remember that on the Belarusian side of the border with Lithuania, there is some information for those travelling abroad. I do not remember exactly what it says, but the information is there. Sometimes I can give it a quick look, as I submit my documents. ”

“ There are billboards on the way to Russia, not every 100 meters, nor 10 kilometres, but when you approach any district or regional centre. I think there’s enough information and you can read even in the dark. The billboards are very large, even huge, they warn about AIDS, about sharing syringes, other bad things. What other information is needed? You can put whatever information you want up there, if a person is bent on these things, billboards will not help. ”

Some participants also mentioned [school as a source of information](#). However, it was 20 years ago when participants were in school.

“ When I was in school, we were taken to the cinema to watch a film about AIDS, that is it. ”

In case information about some diseases was urgently needed for a respondent or someone else, the majority would search on the [Internet](#); some said that they would go to the doctor.

“ I would find out on the Internet via any search engine. ”

“ There’s the Internet; if there is something else, then there is a medical centre nearby. ”

“ If I had to find information, I would go to the doctor. ”

“ I would ask my wife and children; they are all doctors. ”

“ I would tell them about the ways of transmission and preventive measures, yet I would search the Internet for information on treatment and diagnostics. ”

Some people prefer searching the [Internet](#) to visiting a doctor because they are [afraid of disclosure](#) of even the very fact of conversation about intimate diseases, which is especially the case for small towns.

“ The biggest problem is, and that is why we are searching for information via the Internet, is that we feel embarrassed and fear to talk directly to a doctor because we are not sure they would respect medical ethics. If the town is small, people know each other, and it is not uncommon that, if there is a problem, this information will spread very quickly. If the problem is already there, then you try to go to a commercial medical centre, to Minsk or somewhere further away. ”

Participants would prefer to receive information about HIV, STIs and hepatitis C through communication channels in their work, such as a one-hour presentation at the drivers' further training courses or that domestic FM radio stations run a series of thematic broadcasts. Pertinent information could also be placed via the Internet, taking into account the specifics of drivers' profession.

“It would be good to make an hour for that at the BAMAP [drivers'] courses.”

“The information could be distributed through FM radio stations.”

Information of interest to this group are transmission modes, treatment, preventive measures, diagnostic methods, methods of emergency prevention, and location of institutions where they can get help. Nevertheless, respondents demonstrate an established opinion that HIV, STIs and hepatitis C prevention should be carried out among young people through educational institutions and doing that among older people it is too late.

“We must speak about this problem with children at schools, rather than grown-up men of 30 and over. Sexual life nowadays begins at an earlier age than before, by this time a person should know what, how and how much.”

3.2.2. Behavioural risk

Participants believe that intravenous drug use is hardly common among drivers, explaining this by the fact that drivers are exposed to permanent medical control by their employers at the time of hiring and before each trip. They are also randomly checked by the traffic police, who are trained to detect a state of intoxication. When crossing the border, cars and drivers also undergo checks for narcotic substances.

“If a driver had been an injecting addict, it would have been revealed quickly. It is almost impossible to transport narcotic substances across the border. Even if they do not search the vehicle every time, they will understand by body language, the way one speaks. Besides, there are always dogs that are trained to find drugs. Therefore, I believe it [narcotics use] is practically non-existent among drivers. I have been working for 19 years, I have never seen or heard anything like that.”

“I believe that this is not a place where you can use (drugs). The road will forgive no mistakes. If someone uses drugs, they are just soft drugs.”

According to the respondents, alcohol consumption is more common, but only during long idle hours when queuing at the border or during forced idle hours due to loading delays, or when the roads are closed during holidays in some countries. Constant control and self control are exerted over the driver's condition throughout the trip. According to the requirements in some countries a car must be equipped with at least two alcohol testers to ensure that drivers could monitor the level of alcohol in their blood. After such a check, each driver can decide for himself whether he wants to go further or not. Besides each company gets their drivers' civil liability insured outside Belarus (a green card). Moreover, an insurance company can refuse payment if a driver was in the state of intoxication, or the level of alcohol exceeded the norm.

“There are 20–30 per cent among us who drink alcohol without any measures. If a person is inclined to drinking, driving will not stop him. I saw a lot of such cases during my driving career; sometimes we had to take the cars from such drivers.”

“Everything depends on a person, rather than a profession. I myself drink alcohol within reasonable limits. When we have a long break, it happens that people get together, we need to while away the time with something, to take the road off your mind.”

When asked about any **risky circumstances** during a trip, where they can get infected with HIV, STIs, or hepatitis C, the participants named the following:

- When **receiving medical services**, if something happens on the road;
- By **providing first aid** in case of an accident, if there are wounds on the hands;
- Through **casual sexual contact** during a journey.

“For example, you go to the hospital, how do you know if these syringes are disposable or not disposable? You get infected, and then they tell you: ‘Well, sorry, things happen.’ There were cases like that.”

“Anything can happen during a trip; someone might get injured in an accident (traffic accident) and will need help, you can get infected through blood if there are wounds on your hands.”

According to the respondents, **sexual services** are available in all countries where they went, and also in Belarus, despite the fact that prostitution has not been legalized there. Almost all drivers mentioned that they know where on the road the sex workers stand, they even share such information with colleagues through radios in their cars. Some respondents believe that it is safer to use sex services at a brothel abroad than on parking lots in Belarus because girls’ health abroad is better controlled.

“Such services are available everywhere; somewhere they are more civilized, somewhere less. In Poland, there are special hotels, brothels. Such services are advertised through a car radio; you can order a girl to be delivered to you; they can also come to pick you up and bring you back. You can get everything if you pay money.”

“When you go from Minsk to Mogilev, there is a metal warehouse there. Previously, there was a stop; now only good-time girls are standing there.”

“At the parking lots for trucks and vans, the girls would come up and offer their services. An experienced driver will always see such a girl.”

“You see many girls when you drive. Guys often communicate with each other over the radio, laugh at someone, and discuss who is beautiful, who is ugly, and what the prices are.”

3.2.3. Prevention

The participants named the following HIV, STIs and hepatitis C **prevention measures**:

- **Avoid casual sexual contacts**;
- Be aware of **personal safety measures**;
- **Use condoms** during sexual intercourse with non-regular partners;
- **Wash your hands** more often (to prevent hepatitis A).

All the respondents said that **condoms are available everywhere**, they can be purchased at gas stations, pharmacies and shops along the road at the territory of Belarus. In other countries, there are condom vending machines at gas stations and parking lots. Some respondents still keep two condoms in the medical first-aid kit in the car, even though this is no longer required. They also mentioned that

women who provide sexual services always have condoms. At the same time, one of the survey's participants expressed fear that *"condoms do not protect against HIV."*

"I always have two condoms in the vehicle's first-aid kit. Such is the rule."

"If neither a girl nor myself have condoms, you can always ask your colleague. Someone would always stop on the road. Besides, there are special vending machines in European countries. There are pharmacies on the road. They are sold at any gas station."

"These ladies on the road, who offer services, always have condoms. They are good girls in this regard. At least it used to be so; now I do not know, I got married."

3.2.4. HIV testing

In case of need of HIV testing, the majority would go to [special medical centres for anonymous examination](#); some would go to a [local polyclinic](#). One respondent correctly named the location of such a centre.

"Some time ago I took my wife for medical screening before an operation and saw an ad saying it was possible to get tested for HIV anonymously at the centre located near the Musical Comedy Theatre [in Minsk]."

"If I decided to get tested for HIV, I would find a place via the Internet."

"I would go to my local polyclinic."

Participants know that it is [possible to be screened for STIs at a dermato-venereology dispensary \(STD clinic\)](#), a [local polyclinic by a dermatologist](#), or a [commercial medical centre](#), depending on the purpose. If one needs a medical certificate or a health permit, a local polyclinic will be preferred. In case of suspected consequences of unprotected sexual contact, a commercial medical centre would be chosen to ensure higher confidentiality and anonymity of the results. The respondents did not know where they can get tested for hepatitis C.

"Situations are different. If we need to get tested to get a health permit, we have no fear, because we are sure that everything is fine. Moreover, when we know that there is some kind of trouble, I would not go to my polyclinic; I would choose a commercial medical centre, only to make sure nothing would come up."

The majority of respondents had been [tested for HIV during the medical examination while entering military service](#), in the [hospital](#) if they got there for some reason, or when they got compulsory pre-employment medical screening. Many people mistakenly believe that they were tested for HIV every time they had their blood tested. When describing the process of HIV testing, everyone mentioned that they had their blood taken from the vein and were told when the result was ready, but [no one mentioned any pre-test and post-test counselling](#).

[None of the participants knew of a possibility to do a self-test for HIV](#) at home with the help of a saliva test that could be purchased from a drugstore.

"I do not believe you can do HIV test by yourself. After all, everyone knows about a pregnancy test, but no one knows about an HIV test, which can be bought somewhere. Let's say I do not know anything about it and I have never heard about it."

3.3. Results of the survey of international students studying at universities in the Republic of Belarus

Practically all international students in the sample are young people under 25 years of age (93%). Over three-quarters of them (77%) are single. Seventy per cent stayed in Belarus for 12 months or longer, residing in the national or provincial capitals. Respondents appear to be well-off, with 31 per cent describing their financial standing as “excellent” or “above average” (21%). Details are available in Annex 3.

SUMMARY

- The level of knowledge of international students on the test window and the stages of the disease is not high.** Less than half of the students (47.6%) know that AIDS is the last stage of HIV, while 14.8 per cent believe that HIV and AIDS are the same diseases; and 18.2 per cent consider HIV and AIDS to be two different diseases. Nineteen per cent of respondents answered that they were not sure. The level of students’ knowledge about the HIV test window period is not very high either. Only 31.1 per cent of the respondents know that HIV can be detected in the blood three months after infection, with more than a third (34.5%) failed to provide an answer to this question. Students were poorly informed about the potential of HIV antiretroviral therapy. Thus, only less than half (46.7%) of respondents know that an HIV-positive person could maintain good health for many years if he/she takes special medicines (antiretroviral therapy).
- Although the majority (more than a half) of respondents are aware of the main ways of HIV transmission, the level of knowledge on HIV transmission is fragmentary.** Only 12.3 per cent of students answered all questions about the different HIV transmission modes correctly. Depending on the question, between 57.3 per cent and 74.6 per cent managed to answer it correctly. This indicator is the highest for the question “*Can one be infected with HIV by sharing instruments (syringes, needles, etc.) during the intravenous drug use?*” (74.6% of students gave correct answers), and the lowest for the question “*Can a healthy-looking person have HIV?*” (57.3% answered correctly). Only 71.8 per cent of students surveyed believe that condom use could reduce the risk of HIV transmission. Sixty-six of respondents know that it is possible to become infected with HIV while getting a tattoo, a manicure or shaving with non-sterile instruments). Only 60.1 per cent of students agree that staying faithful to one uninfected sexual partner can reduce the risk of HIV transmission. Students also display many common misconceptions related to HIV transmission. Only 38.7 per cent of respondents know that HIV is not transmitted by mosquito bites, whereas 31.3 per cent believe it is, and 30 per cent of respondents failed to answer this question. 44.7 per cent of the students interviewed know that HIV is not transmitted by sharing utensils and household items (using a shared bath, a pool, a toilet with an HIV-infected person); 23.6 per cent believe it is; while a quarter of respondents (31.7%) failed to answer this question.
- The vast majority of international students have been exposed to information about HIV, and more than half of them mentioned the internet as a source of information.** Eighty-eight per cent of students received information about HIV/AIDS. The respondents received information about HIV from various sources. The main source of information for foreign students was the Internet: 51.4 per cent mentioned this source, 37.6 per cent of students received information from television programmes and advertising, 29.3 per cent of

respondents at the university; 24.4 per cent from medical personnel at medical centres; 24.1 per cent from special literature, leaflets, and booklets.

Of all respondents who received information about HIV/AIDS, 19.9 per cent of respondents received such information mainly in Belarus; 29.9 per cent both in Belarus and in another country, 43.4 per cent mainly in another country. Thus, 49.8 per cent of international students received information about HIV mainly or partly in Belarus.

4. **About two-thirds of the international students reported being aware of sexually transmitted infections (STIs). However, the level of knowledge on the prevention of STIs is rather low.** Sixty-six per cent of international students indicated that they are aware of the existence of sexually transmitted infections, 33 per cent do not know about such infections, one per cent failed to answer this question. Of those who reported being aware of STIs, 45.5 per cent have been tested for sexually transmitted infections (syphilis, gonorrhoea, herpes, chlamydia, etc.) over the last six months. Thirty per cent of all respondents have been tested for sexually transmitted infections over the last six months. The majority of respondents (81% of the respondents who reported being aware of STIs) believe that it is possible to avoid STIs during sexual intercourse with a non-regular partner by always using a condom. Twenty per cent noted that treating reproductive organs with disinfectants (miramistin, chlorhexidine) after unprotected sexual intercourse makes it possible to avoid infection.
5. **The level of awareness on hepatitis C is low, especially concerning transmission, and less than 10 per cent got tested for this disease in the last six months.** Fifty-eight per cent of international students are aware of hepatitis C, while 41 per cent of respondents indicated that they did not know about this infection and 1.2 per cent failed to provide an answer. Of those respondents who know about hepatitis C, 16.2 per cent (which is 9.4% of the total number of the respondents) have been tested for hepatitis C over the last six months. The level of knowledge of respondents, *who reported being aware of hepatitis C*, about the ways of transmission of hepatitis C was low. Thus, when choosing the ways of transmission, only 69.5 per cent of respondents mentioned that hepatitis C could be transmitted by shared use of instruments (syringes, needles, etc.) to inject a drug; 58.1 per cent that hepatitis C can be transmitted while getting a tattoo, a manicure or shaving with non-sterile instruments; 40.4 per cent via sexual intercourse without a condom. At the same time, misconceptions on the transmission of hepatitis C were also mentioned, such as 26.1 per cent of the respondents who are aware of the disease believed that hepatitis spread via airborne transmission; 22.7 per cent believed that it could be transmitted while eating with dirty hands; and 17.2 per cent by mosquito bites. Of all the students interviewed, 9.7 per cent correctly named all actual routes of transmission of hepatitis C correctly.
6. **More than two-thirds of international students who were sexually active in the last year, had sexual intercourse with a non-regular sexual partner, with three different partners on average. As only 57.7 per cent reported always using a condom with a non-regular sexual partner, the level of behavioural risk with regard to HIV among this group can be considered high.** Of those students who reported having ever had sexual intercourse, 83 per cent (81.5% males and 88.9% females), or 43 per cent of the total number of respondents, have had sexual intercourse over the past 12 months. Sixty-nine per cent of respondents have had sex with a non-regular sexual partner over the last 12 months. The majority of respondents (73%) who had a non-regular sexual partner over the last

12 months had contacts with more than one partner, with three different sexual partners on average (median number).

Seventy-eight per cent of respondents who had sex with a non-regular partner used condoms during their last intercourse with a non-regular partner. Fifty-eight per cent of respondents always use condoms with non-regular sexual partners. Non-use of condoms with non-regular partners was explained by several reasons of a subjective nature such as: “Condoms reduce sexual pleasure” (27%), “I trust my partner” (27%), “I am not used to it” (23%), “I do not use it if I think that my partner is healthy” (20%) and “Condoms are not always available when needed” (15%), etc.

7. **More than 10 per cent of those with a regular sexual partner also reported having sexual intercourse with a non-regular sexual partner in the last 12 months, and 63.2 of those reported always using a condom with a non-regular sexual partner.** Of those respondents who have had sexual intercourse over the last 12 months, 41.1 per cent had a regular sexual partner. 10.8 per cent of respondents (38 persons) have had sexual intercourse with both regular and non-regular partners during the last 12 months. 86.8 per cent of such respondents used a condom in their last sexual intercourse with a non-regular partner. Sixty-three per cent of respondents who have had sexual intercourse with regular and non-regular partners in the past 12 months always used a condom with a non-regular sexual partner. Thus, regular partners of persons who have sex with both regular and non-regular partners are also at risk of getting infected with HIV.
8. **More than 10 per cent (15 males and 2 females) reported having engaged in transactional sex, and less than two-thirds used a condom in this situation, and more than 10 per cent (all males) purchased sexual services in the last 12 months, and about half of them used condoms.** Five per cent of respondents did not answer this question. The condom was used by 11 persons out of 17 (64.7%) during their last transactional sexual contact. Of all respondents who have had sexual intercourse over the last 12 months, 11.3 per cent (all males) purchased sexual services (remunerated their partner for sex). Five per cent of respondents did not answer this question. Nine persons out of 17 used condoms during their last purchased sexual intercourse. It can be assumed that the prevalence of commercial sex in the target group and the level of sexual risk involved in commercial sex are quite high. Therefore, further research on this topic is considered to be highly relevant.
9. **International students’ assessment of their personal risk of HIV infection is controversial, and only over one-quarter of respondents (27.2%) believes that they are at risk to become HIV-infected. Women consider themselves less at risk than men.** Eighteen per cent answered “yes”, 8.9 per cent “more likely ‘yes’ than ‘no’”. More than a half of respondents (54.6%) believe that there is no risk to become HIV-infected in their lives (34.9%) or that it is “very unlikely” (19.7%). Eighteen per cent of respondents failed to answer this question.
10. **More than one-third of international students consumed alcohol during the last month, the use of non-injection drugs was reported by 5.7 per cent, and 3.4 per cent reported ever having used injection drugs.** Beer is the most common alcoholic beverage. Of those respondents who consumed alcohol in the last month, 36.7 per cent drank beer. Strong spirits were somewhat less popular (31.7%). Twenty-seven per cent of respondents drank wine; 25.8 per cent consumed low-alcohol beverages; 5.7 per cent of students reported

having ever used non-injection drugs (smoking blends, “weed”, pills, solutions, powders) and 8.8 per cent of respondents did not answer this question. Three per cent of respondents said that they had used injection drugs (once or several times). Seven per cent of students did not answer this question. Since the level of injection drug use was identified as quite high in this target group, further in-depth research will be needed.

11. **Only 58.4 per cent of international students know that they can get tested for HIV, and 18.5 per cent had been tested for HIV in the last six months.** Fifty-eight per cent of international students said that they had a possibility to get HIV tested and 23.6 per cent of respondents believe that they could not get an HIV test at the moment of the survey; 18 per cent were not sure or did not answer this question. There is a correlation ($P < 0.05$) between the answer to the question “Do you currently have a possibility to be tested for HIV?” and the duration of students residing in the Republic of Belarus. The proportion of students who said they could get tested for HIV increased from 33.3 per cent (less than 3 months) to 63.5 per cent (for more than 1 year). Eighteen per cent of all respondents had been tested for HIV infection over the past six months and knew the results. There were no significant differences revealed in the level of HIV-related knowledge between the respondents who had ever been tested for HIV and the respondents who had not.

3.3.1. HIV infection awareness

Less than half of students (47.6%) know that AIDS is the last stage of HIV infection. Fifteen per cent of respondents believe that HIV infection and AIDS are the same diseases; 18.2 per cent consider HIV and AIDS to be two different diseases and 19.4 per cent of the respondents failed to answer this question (Figure 33).

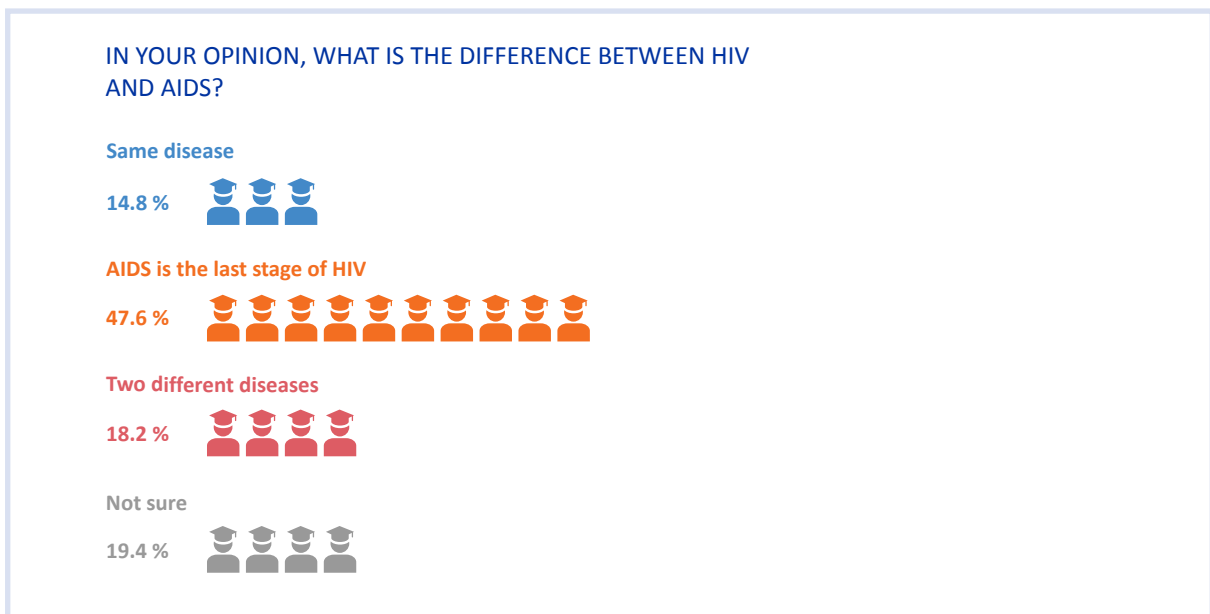


Figure 33. Percentage distribution of the international students’ responses whether HIV is different from AIDS

The level of students’ knowledge on the HIV test window period is also low. Only 31.1 per cent of respondents know that an HIV infection can be detected in the blood three months after infection, more than a third (34.5%) failed to answer this question (Figure 34).

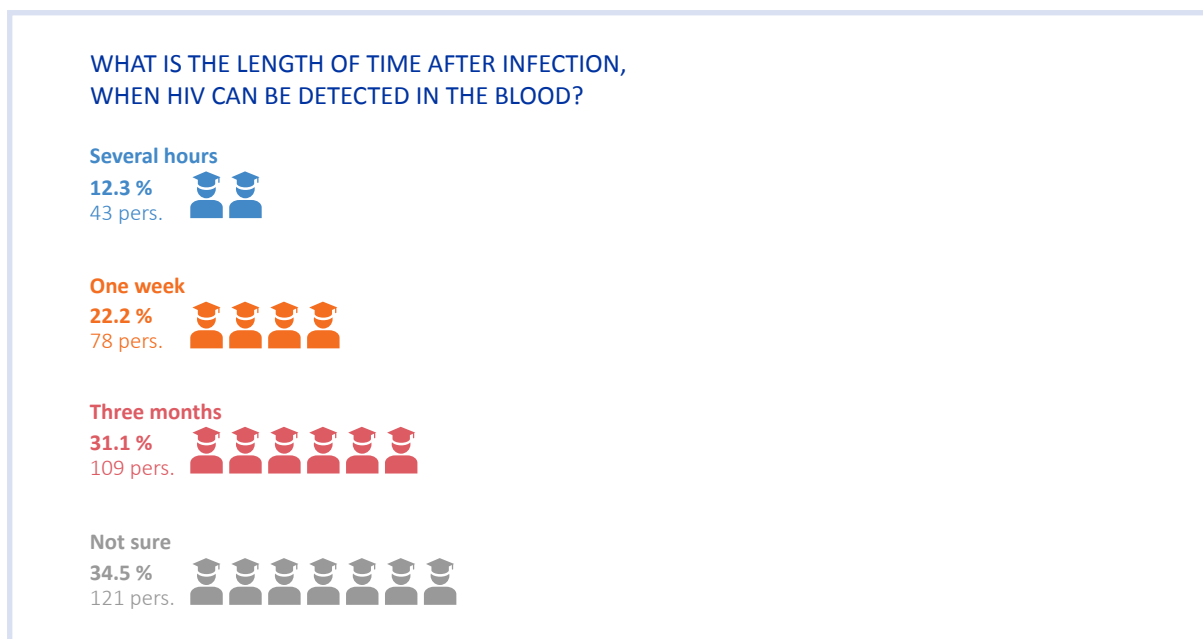


Figure 34. Percentage distribution of the international students' responses to the question of when HIV can be detected in the blood

Students were poorly informed about the possibilities of HIV antiretroviral therapy (ART). Thus, only less than half of respondents (46.7%) know that an HIV-positive person can maintain good health for many years if they receive ART. Thirty per cent of the respondents failed to answer this question (Figure 35).

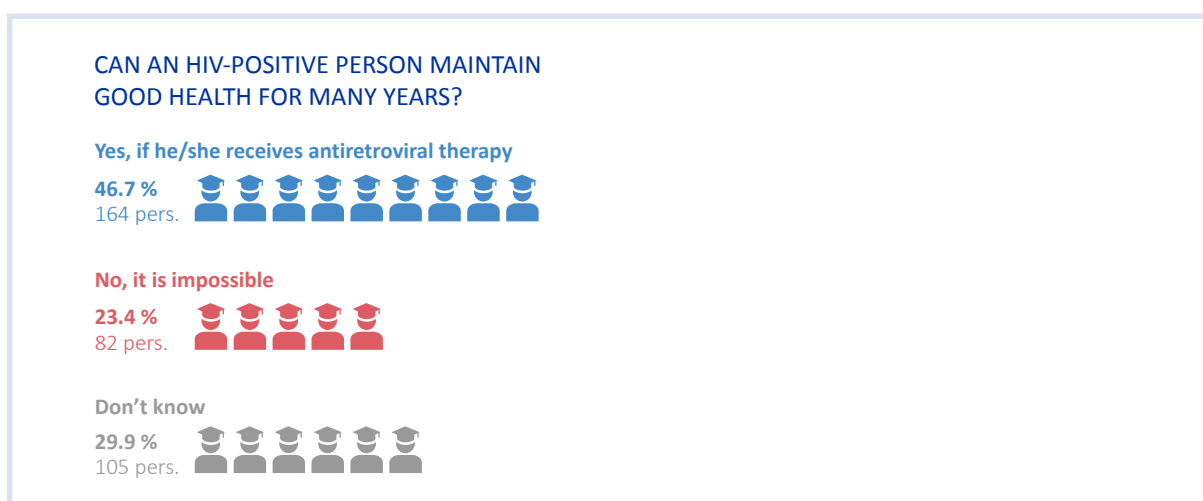


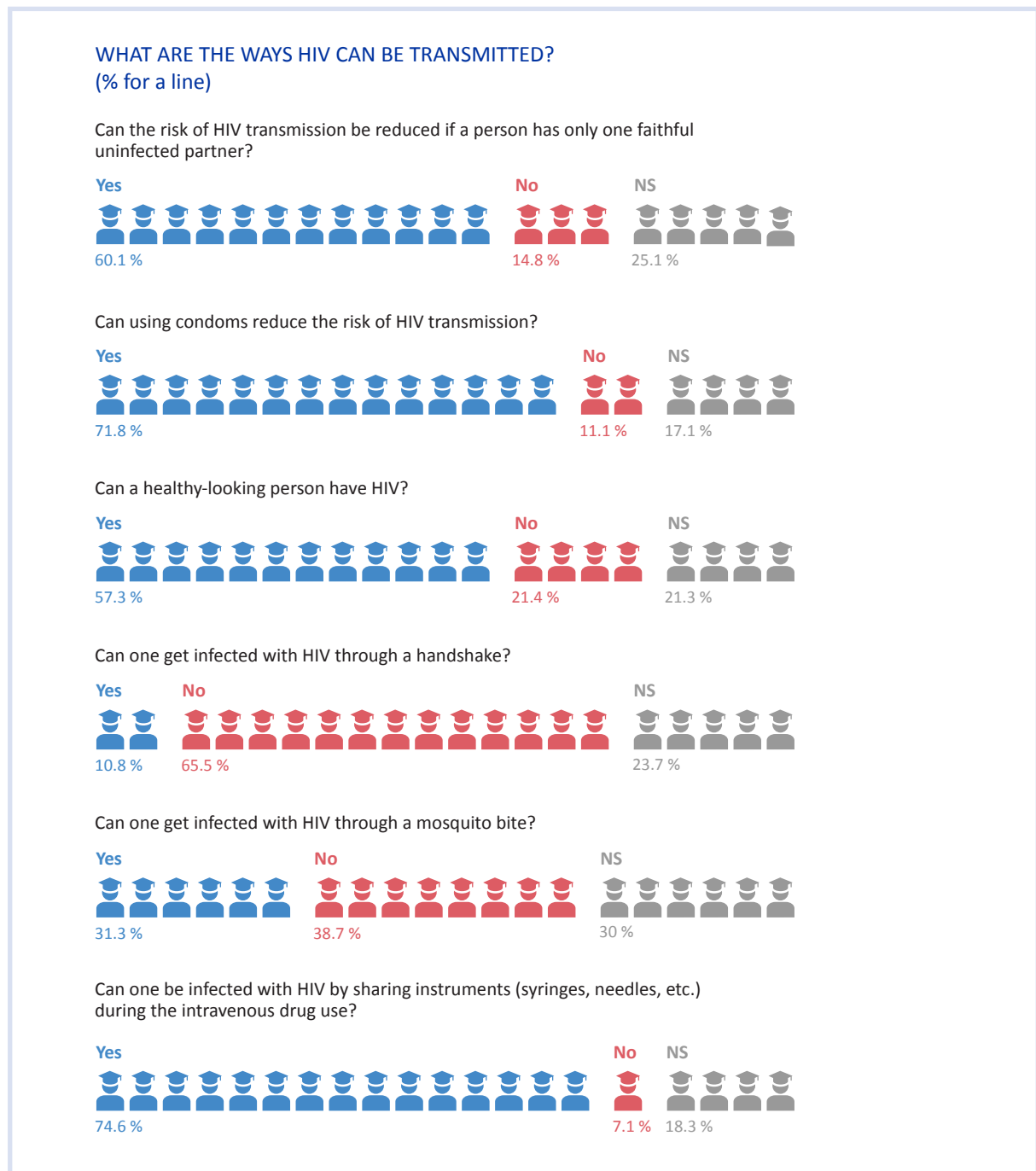
Figure 35. Distribution of international students' answers to the question on the health condition of PLHIV

While most respondents reported being aware of the main routes of HIV transmission, the level of their knowledge cannot be considered high. Thus, the level of knowledge on issues related to actual ways of HIV transmission ranges from 57.3 per cent to 74.6 per cent. This indicator was the highest for the question "Can one be infected with HIV by sharing instruments (syringes, needles, etc.) during the intravenous drug use?" (74.6% of students answered correctly), and the lowest for the question "Can a healthy-looking person have HIV?" (57.3% of respondents answered correctly). Only 71.8 per cent of students believe that it was possible to reduce the risk of HIV transmission by using condoms. Sixty-six per cent of respondents know that it is possible to get infected with HIV while using non-sterile tools

during tattooing, manicure and shaving. Only 60.1 per cent of students agree that it is possible to reduce the risk of HIV transmission by staying faithful to one uninfected partner.

The level of awareness about **false** HIV transmission modes is also low. Thus:

- Only 38.7 per cent of respondents know that HIV is not transmitted through a mosquito bite; whereas 31.3 per cent believed that one could be infected with HIV this way; 30 per cent of respondents failed to answer the question.
- 44.7 per cent of respondents know that HIV is not transmitted through household contacts (using a shared bath, a pool, a toilet with an HIV-infected person); 23.6 per cent believe it is, and almost a third of respondents (31.7%) failed to answer this question (Figure 36).



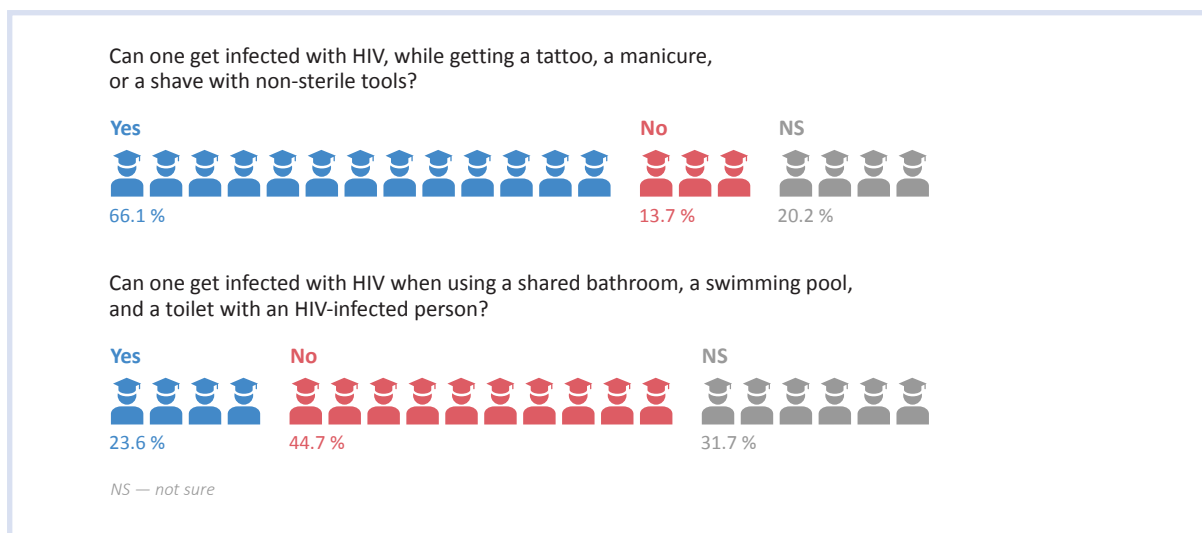


Figure 36. Knowledge of international students regarding HIV transmission

In general, 18.8 per cent of respondents demonstrate a correct understanding of the ways of preventing HIV sexual transmission and at the same time reject main misconceptions related to HIV transmission (for the 5 questions below):

- “Can the risk of HIV transmission be reduced if a person has only one faithful uninfected partner?”
- “Can the risk of HIV transmission be reduced by using condoms?”
- “Can a healthy-looking person have HIV?”
- “Can one get infected with HIV through a handshake?”
- “Can one get infected with HIV through a mosquito bite?”

Twelve per cent of students answered all the questions about modes of HIV transmission correctly.

Eight-nine per cent of students received information about HIV/AIDS. Internet was the main source of information on HIV/AIDS for students (51.4% of respondents who received information about HIV/AIDS). Thirty-eight per cent mentioned television programmes and advertising. Twenty-nine per cent received such information at university classes, 24.4 per cent from medical personnel at medical centres and 24.1 per cent from special literature, leaflets, and booklets (Figure 37).

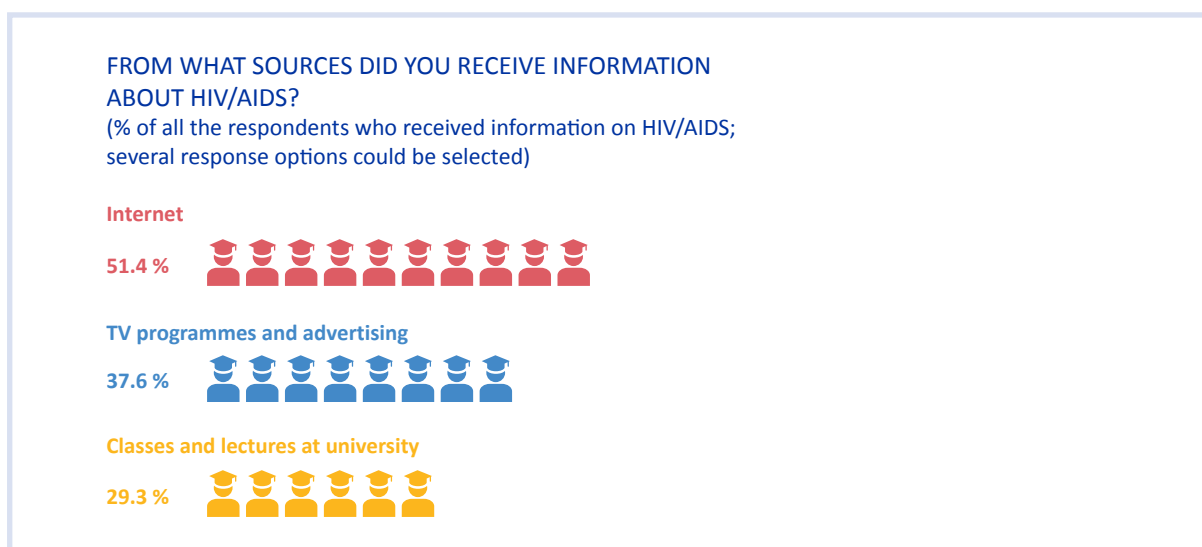




Figure 37. Sources of information about HIV/AIDS among international student respondents

Twenty per cent of respondents (*of those respondents who received information about HIV/AIDS*) received information about HIV mainly in Belarus; 29.9 per cent both in Belarus and in another country, 43.4 per cent in another country; and 4 per cent failed to answer this question (Figure 38).

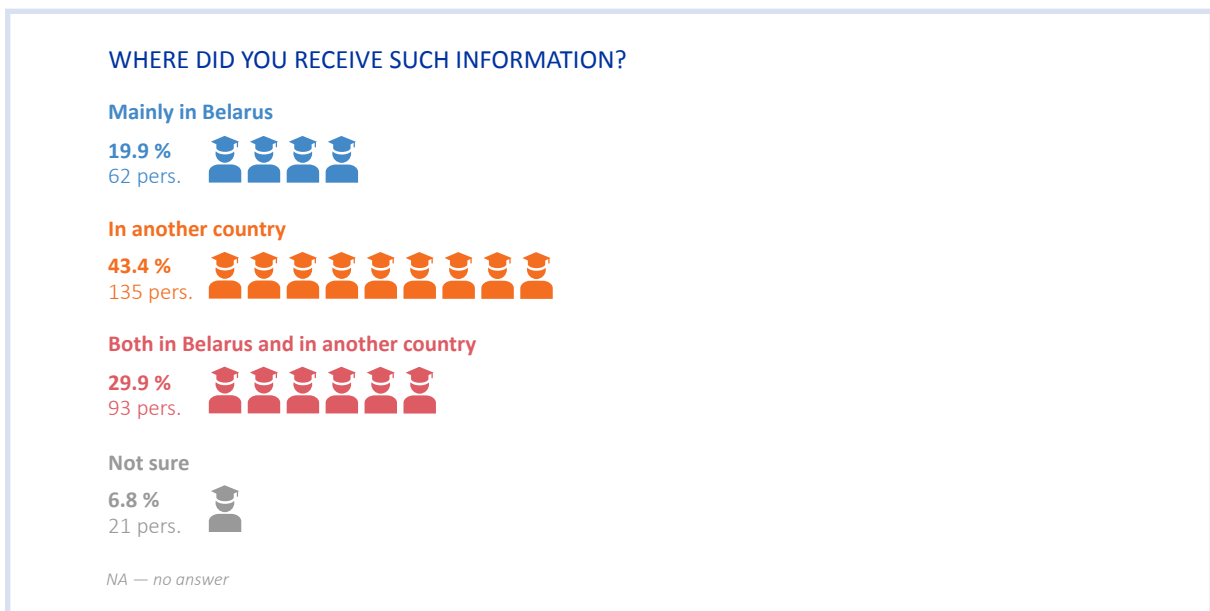


Figure 38. Distribution of international students according to where they received information about HIV

Thus, 49.8 per cent of students received information about HIV mainly or partly in Belarus.

3.3.2. Awareness of sexually transmitted infections (STIs)

Sixty-six per cent of students reported being **aware of the existence of sexually transmitted infections**. Thirty-three per cent of respondents noted that they did not know about such infections, 1.2 per cent did not answer this question (Figure 39).

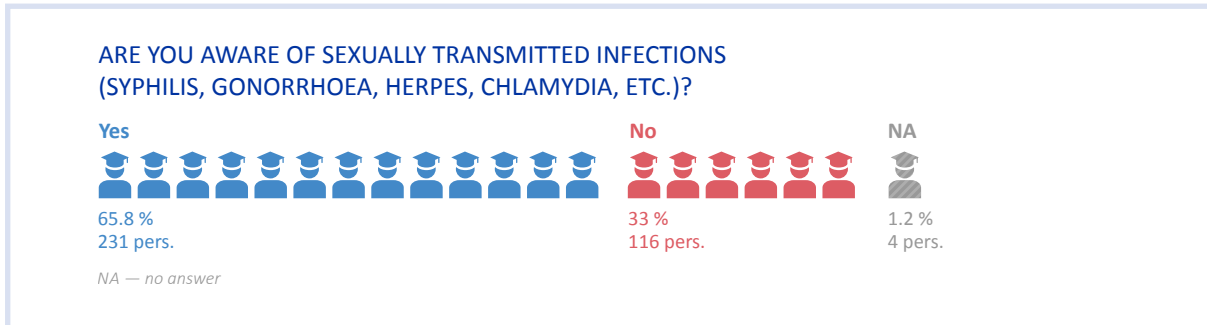


Figure 39. Distribution of international students' awareness of sexually transmitted diseases

Forty-five per cent of respondents (of those respondents who knew about STIs) had been tested for sexually transmitted infections (syphilis, gonorrhoea, herpes, chlamydia, etc.) in the last 6 months (Figure 40).

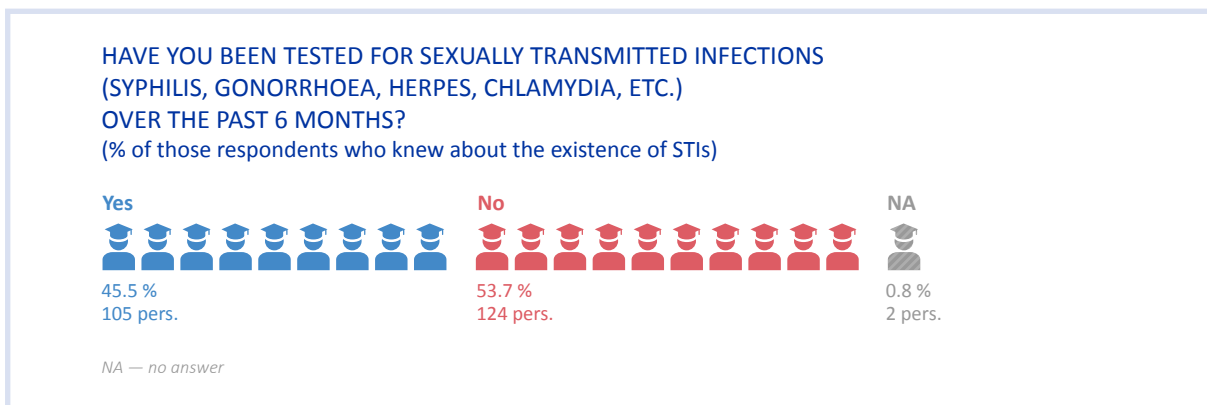
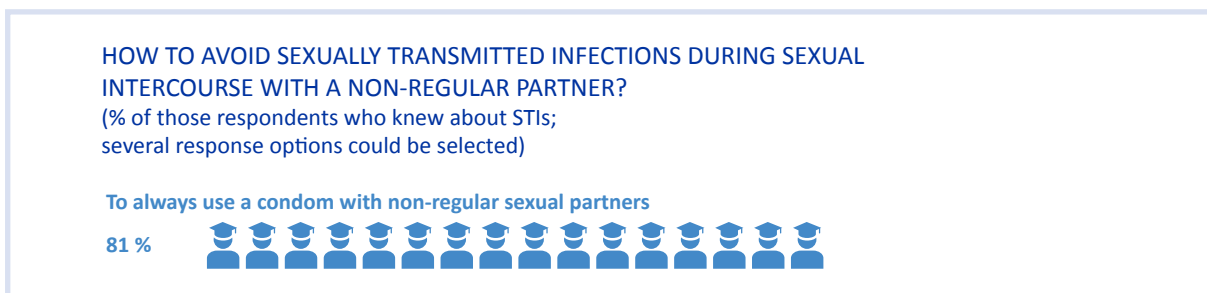


Figure 40. Distribution of international students according to past medical history of having been tested for sexually transmitted diseases over the last 6 months

Thirty per cent of all respondents have been tested for sexually transmitted infections over the past 6 months.

The majority of respondents (81%) (of those who knew about the existence of STIs) believe that it is possible to avoid being infected with STIs during sexual intercourse with a non-regular partner by always using a condom. Nineteen per cent noted that treating reproductive organs with disinfectants (miramistin, chlorhexidine) after unprotected sexual intercourse makes it possible to avoid infection (Figure 41).



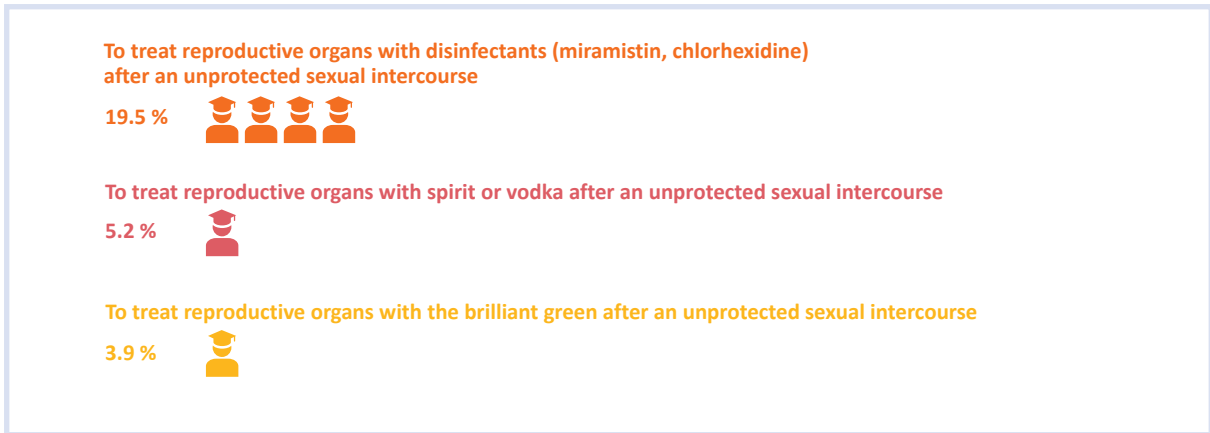


Figure 41. Methods to avoid sexually transmitted infections while having sexual intercourse according to international student respondents

3.3.3. Awareness of hepatitis C

Fifty-eight per cent of students are aware of the existence of hepatitis C. Forty-one per cent of respondents noted that they did not know about this infection, 1.2 per cent failed to answer the question (Figure 42).

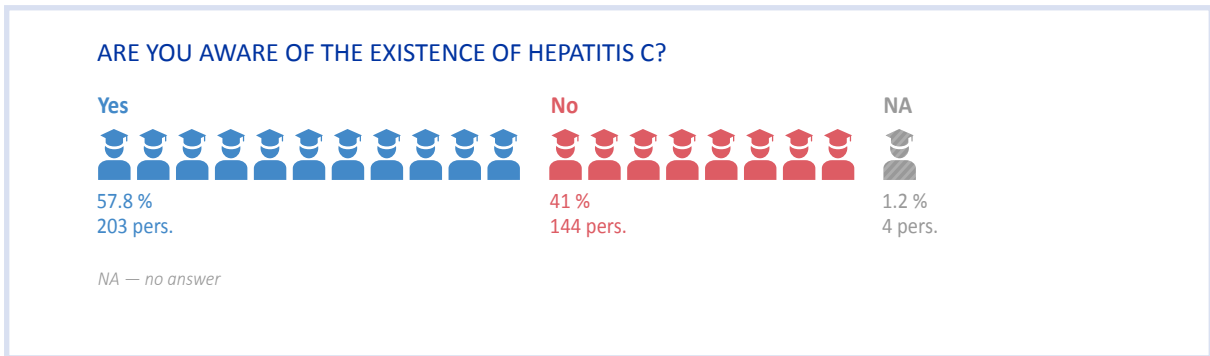


Figure 42. Distribution of international students according to awareness of hepatitis C

Nine per cent of the total number of students interviewed have been tested for hepatitis C over the last 6 months. This is 16.2 per cent of those who knew about hepatitis C (Figure 43).

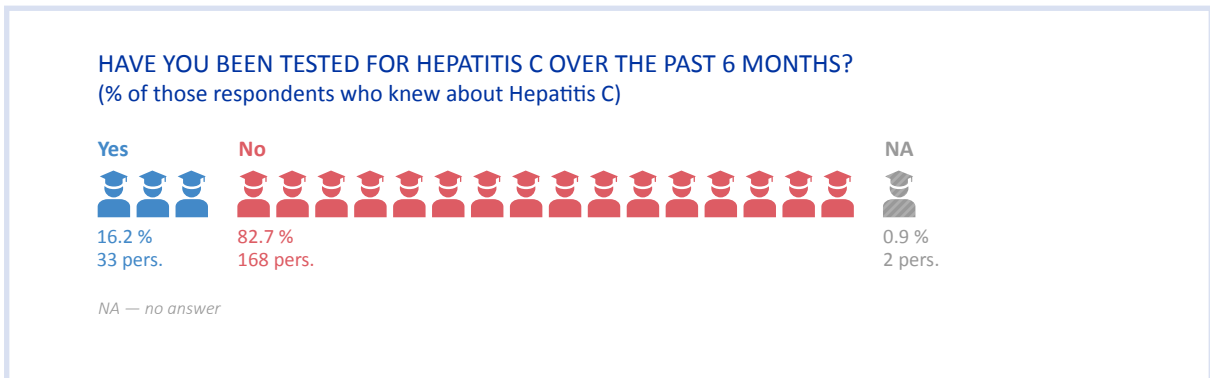


Figure 43. Distribution of international students according to past medical history of having been tested for hepatitis C over the last 6 months

The level of respondents' knowledge about the ways of transmission of hepatitis C is not high. Only 9.7 per cent of students correctly named all existing ways of transmission of hepatitis C:

- 69.5 per cent of respondents mentioned that hepatitis C could be transmitted by sharing instruments (syringes, needles, etc.) when injecting a drug with a syringe (*of those respondents who knew about the existence of hepatitis C*);
- 58.1 per cent know that hepatitis C can be transmitted during tattooing, manicure or shaving with non-sterile instruments;
- 40.4 per cent know that hepatitis C can be transmitted through sexual intercourse without a condom.

At the same time, non-existent ways of hepatitis C transmission were also mentioned:

- 26.1 per cent of respondents believe that hepatitis is spread via airborne transmission;
- 22.7 per cent by eating with dirty hands;
- 17.2 per cent through a mosquito bite (Figure 44).

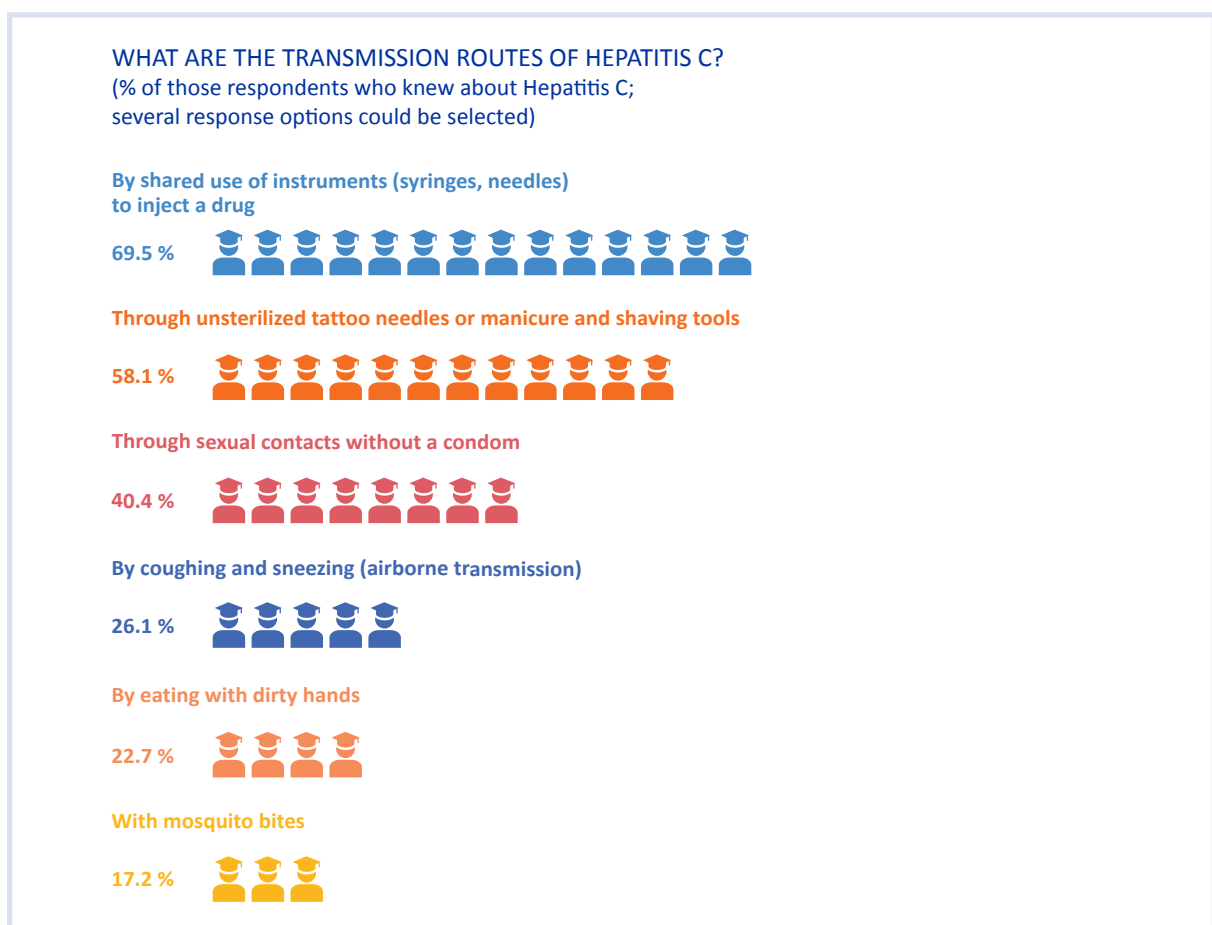


Figure 44. Awareness of transmission routes for hepatitis C among international students

3.3.4. Sexual behavioural risk

Fifty-two per cent of students reported ever having had sexual contact (63.4% males and 26% females). Of those who reported a sexual activity, 83 per cent (81.5% males and 88.9% females), or 43 per cent of the total number of the respondents, had sex over the past 12 months.⁶

Sixty-nine per cent of respondents with an active sexual life had sexual intercourse with a non-regular sexual partner over the last 12 months (Figure 45).

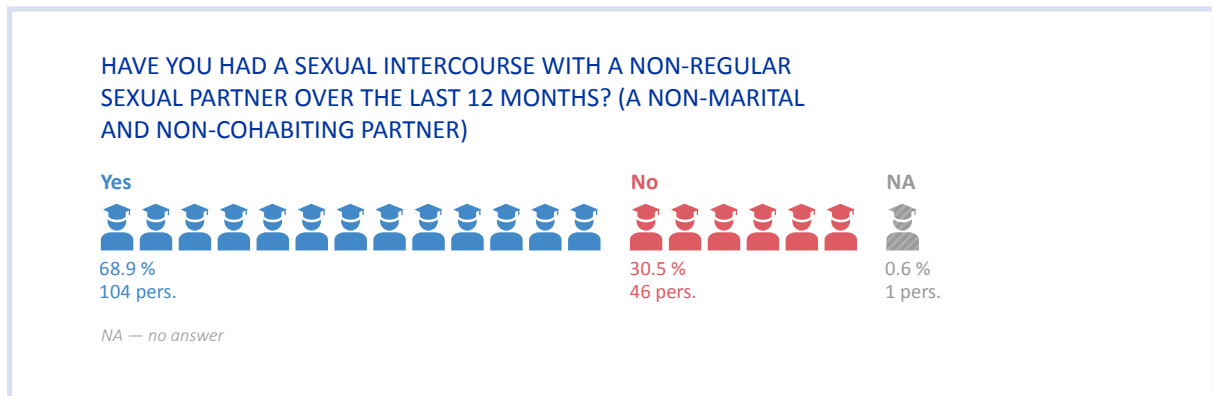


Figure 45. Distribution of international students according to history of having a sexual intercourse with a non-regular partner over the last 12 months

Seventy-three per cent of respondents who had sex with a non-regular partner over the last 12 months, had contacts with more than one partner (Figure 46), with an average three different sexual partners (median number).

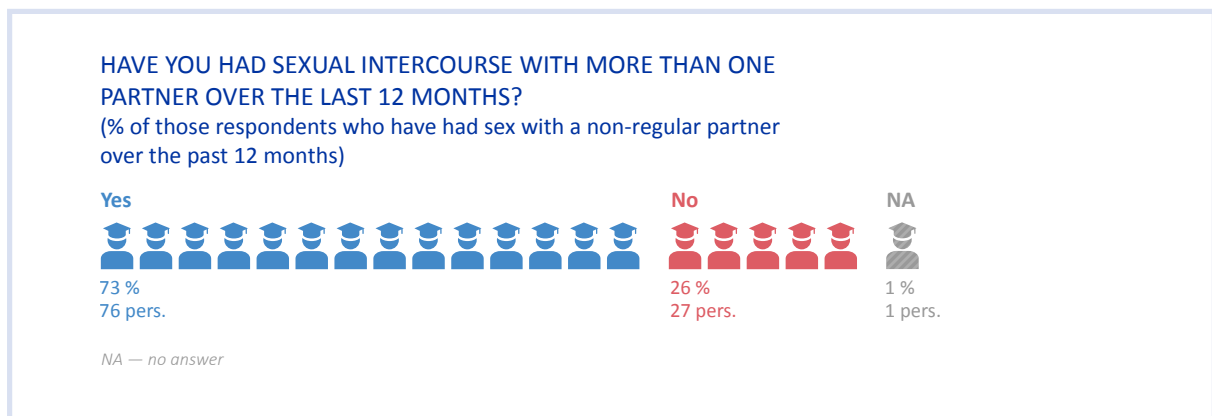


Figure 46. Distribution of international students according to their history of having more than one sexual partner in the last 12 months

Almost eighty per cent of the respondents who had sex with a non-regular partner used condoms during their last intercourse with a non-regular partner (Figure 47).

⁶ The figures provided further in this section are calculated for respondents who reported ever having sexual contacts and had sex over the last 12 months.

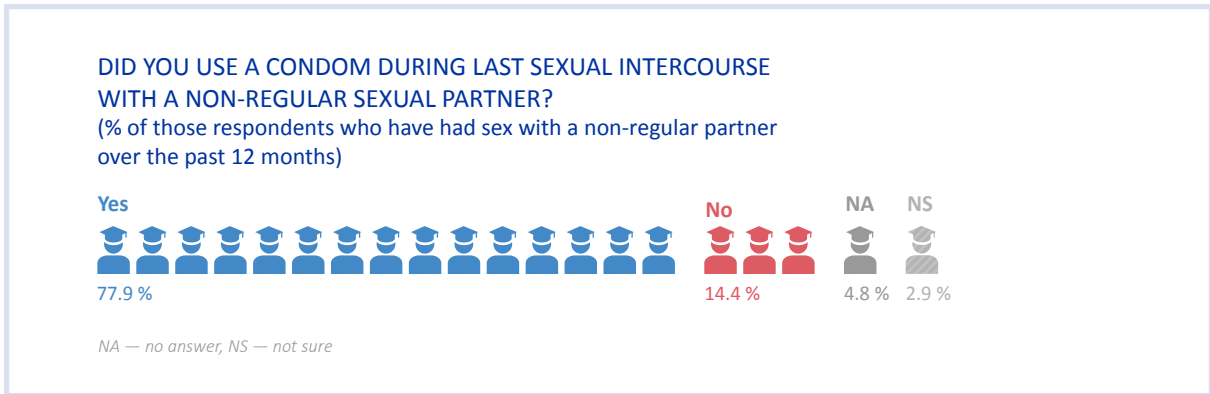


Figure 47. Condom usage among international students during last sexual intercourse with a non-regular sexual partner

Fifty-eight per cent of respondents report always using a condom with non-regular sexual partners (Figure 48).

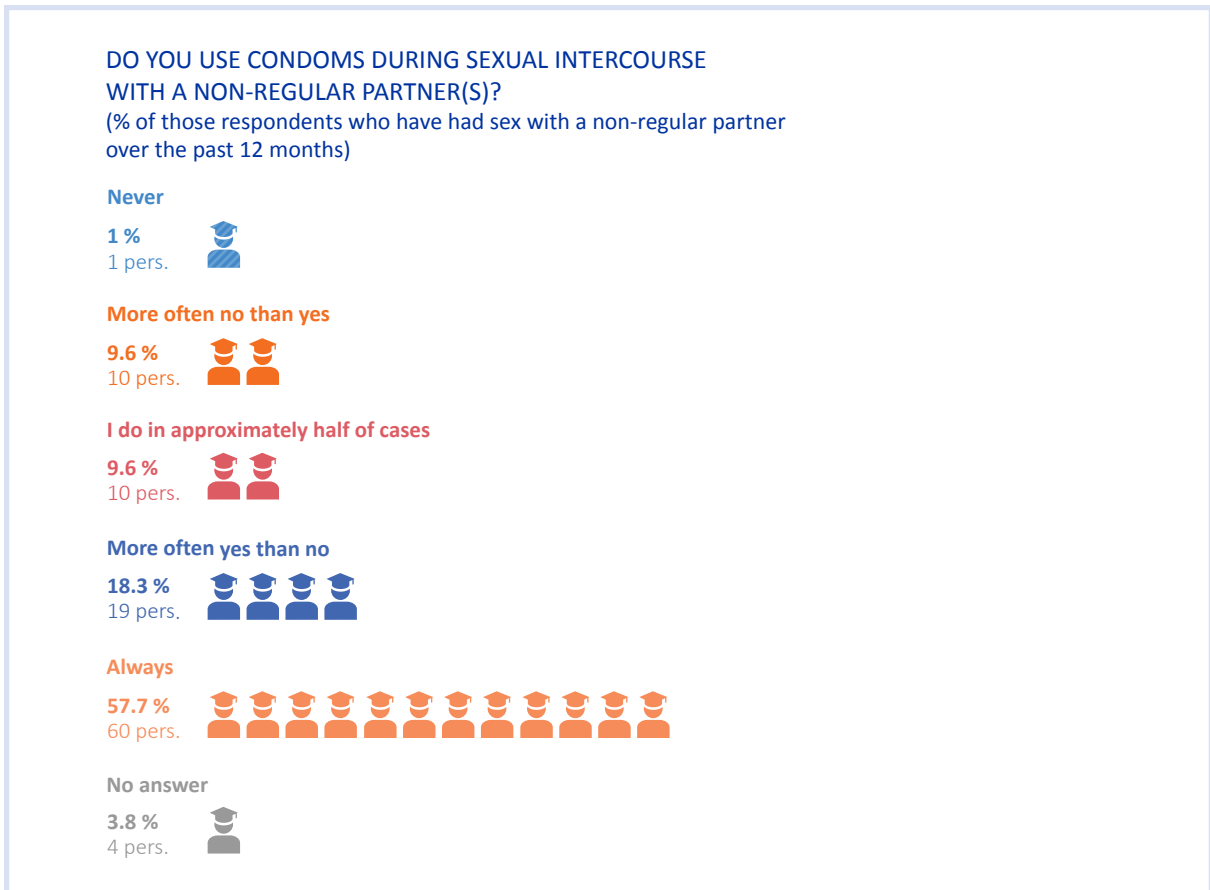


Figure 48. Frequency of condom use during sexual intercourse with a non-regular partner as claimed by international students

Non-use of condoms with non-regular partners was practiced for several reasons, such as “Condoms reduce sexual pleasure” (27%), “When I trust my partner” (27%), “I’m not used to this” (23%), “I do not use it if I think that my partner is healthy” (20%), “Condoms are not always available when needed” (15%), etc. (Figure 49).

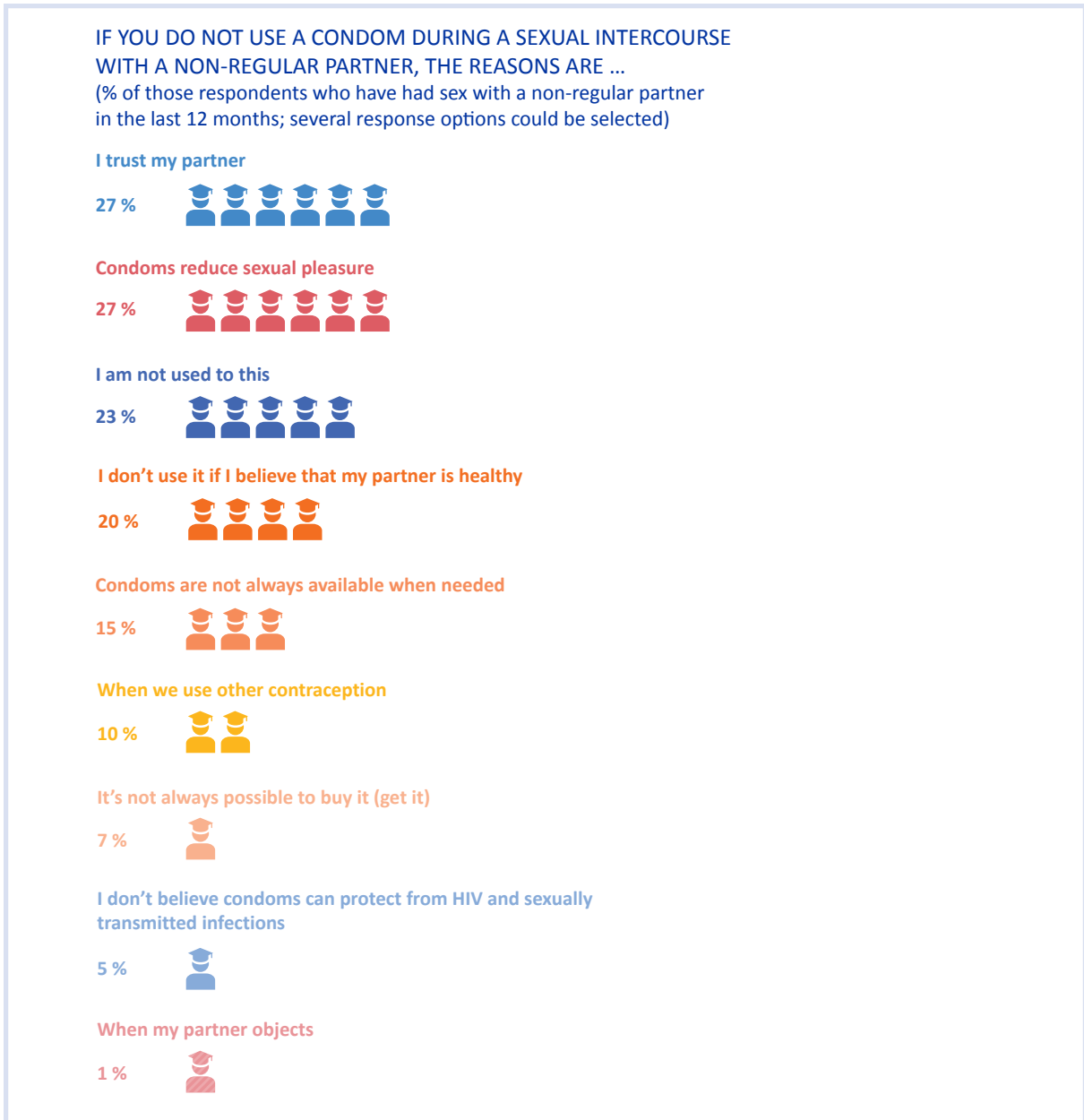


Figure 49. Reasons for not using condom during last sexual contact with a non-regular partner according to international students

Forty-one per cent of respondents have a regular sexual partner (Figure 50). Of all the respondents who had sexual intercourse over the past 12 months, 32.5 per cent males and 83.3 per cent of females have a regular sexual partner.

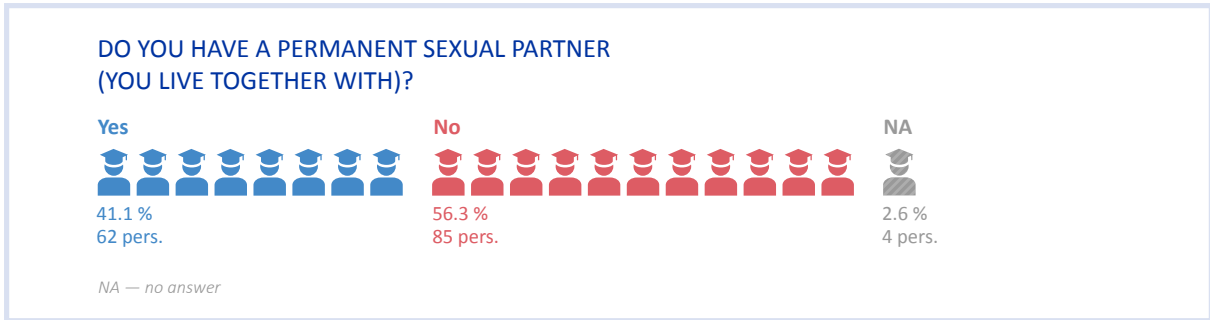


Figure 50. Availability of a regular sexual partner according to international students

Eleven per cent of respondents (27 persons) had sexual intercourse with both regular and non-regular partners over the last 12 months. Eighty-seven per cent of them used a condom during their last sexual intercourse with a non-regular partner (Figure 51).

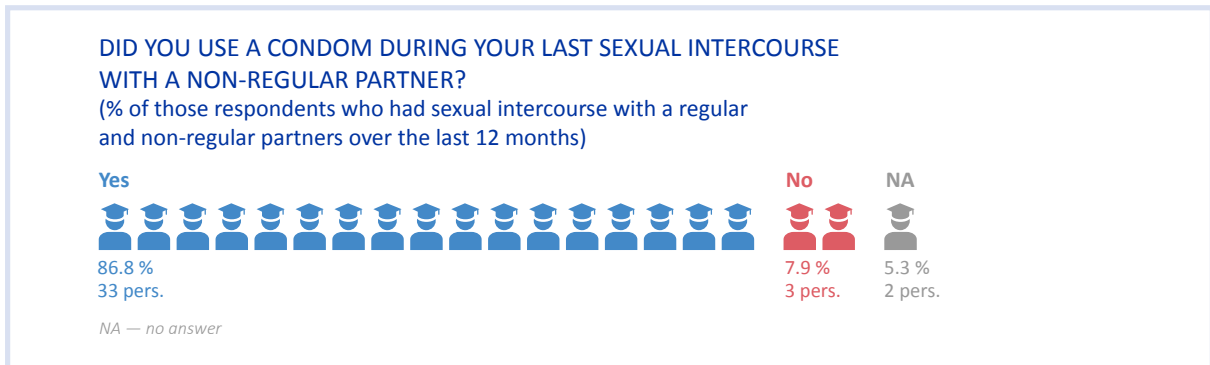


Figure 51. Condom usage during last sexual intercourse with a non-regular partner according to international students

Sixty-three per cent of respondents who had sexual intercourse with regular and non-regular partners over the last 12 months always used condoms with non-regular sexual partners (Figure 52).

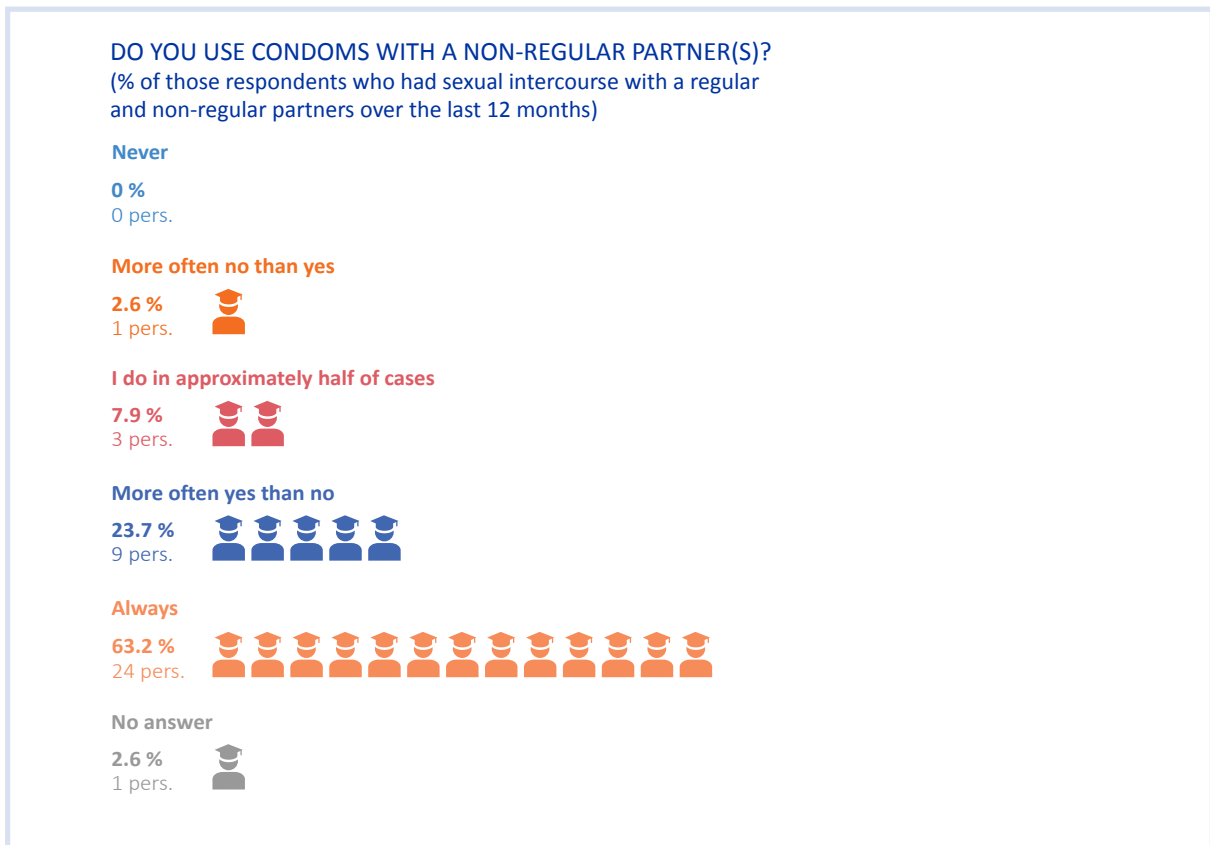


Figure 52. Frequency of using condoms with a non-regular partner according to international students

Of all students who had sexual intercourse in the past 12 months, 11.3 per cent (15 males and 2 females) reported having engaged in transactional sex in the last 12 months. Five per cent of respondents did not answer this question (Figure 53).

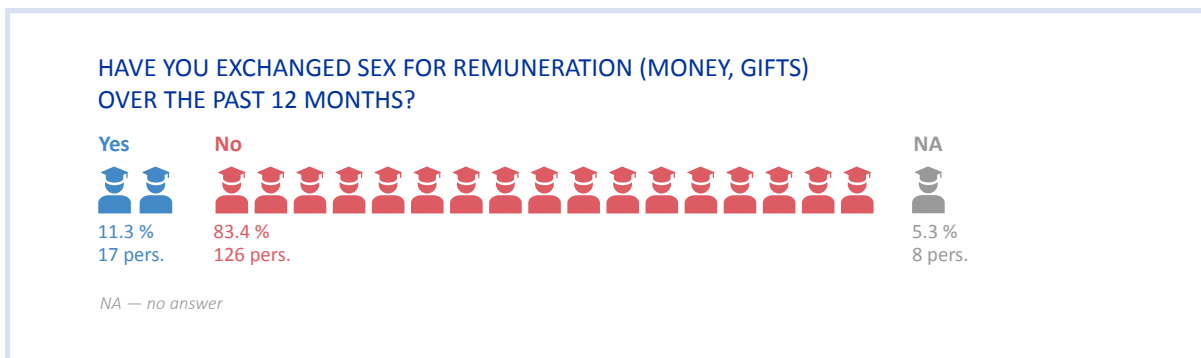


Figure 53. Distribution of international student according to history of exchanging sex for remuneration over the past 12 months

Condoms were used by 11 persons out of 17 (64.7%) during their last transactional sex contact. Of all respondents who had sexual intercourse over the last 12 months, **11.3 per cent** (all males) **purchased sexual services** (remunerated their partner for sex); 4.6 per cent of respondents did not answer this question (Figure 54).



Figure 54. Distribution of international students according to history of remunerating their partners for sex in the past 12 months

3.3.5. Use of psychoactive substances

Thirty-four per cent of students consumed alcohol during the last month (Figure 55). Alcohol was consumed by 37.8 per cent of males and 26 per cent of females.

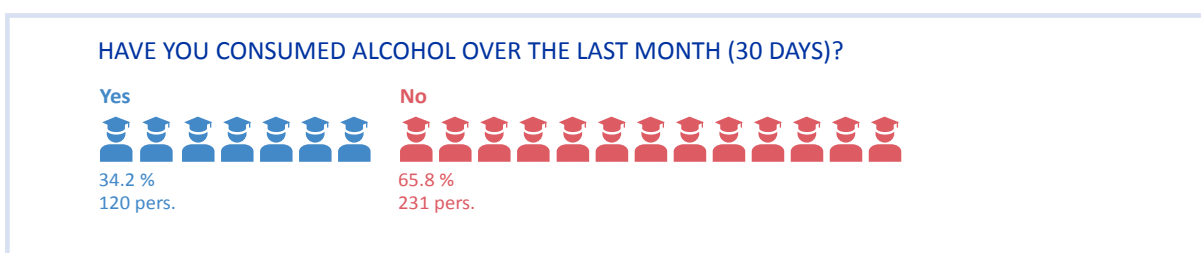


Figure 55. History of alcohol consumption over the past 30 days among international students

Thirty-seven per cent of all respondents who consumed alcohol in the last month drank beer. Strong spirits were less popular (31.7%), 26.7 per cent consumed wine, 25.8 per low-alcohol beverages (Figure 56).

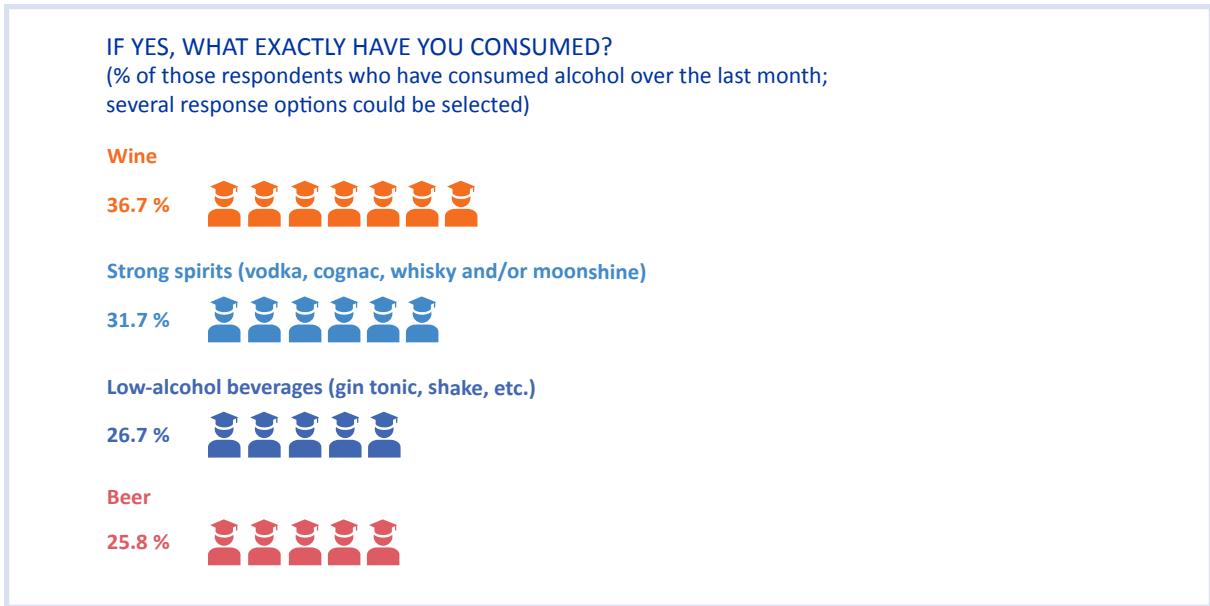


Figure 56. Alcohol preferences among international student

5.7 per cent of students reported having ever used **non-injection drugs** (smoking blends, “weed”, pills, solutions, powders) (Figure 57).



Figure 57. Distribution of international students according to history of ever-used non-injectable drugs

3.4 per cent of respondents said that they had **used injection drugs (once or several times)**. 7.1 per cent of students did not answer this question (Figure 58).

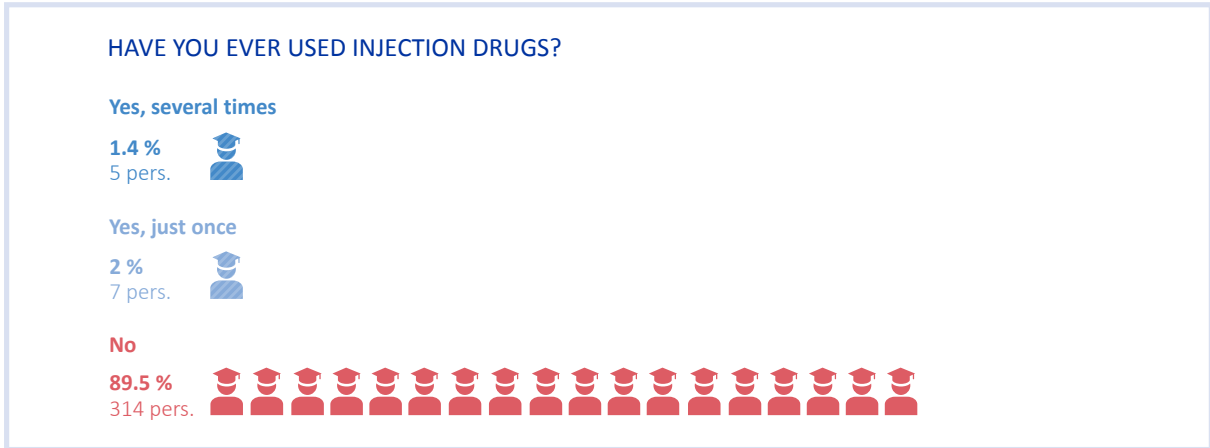




Figure 58. Distribution of international students according to history of ever-used injectable drugs

3.3.6. HIV testing

More than a quarter (27.2%) of students believe there is a real risk for them to get infected with HIV (18.3% answered “yes”, 8.9% “more likely ‘yes’ than ‘no’”). More than half of respondents (54.6%) believe that there is no risk to become HIV-infected in their lives (34.9%) or that it is “unlikely” (19.7%). 18.3 per cent of respondents failed to answer this question (Figure 59).

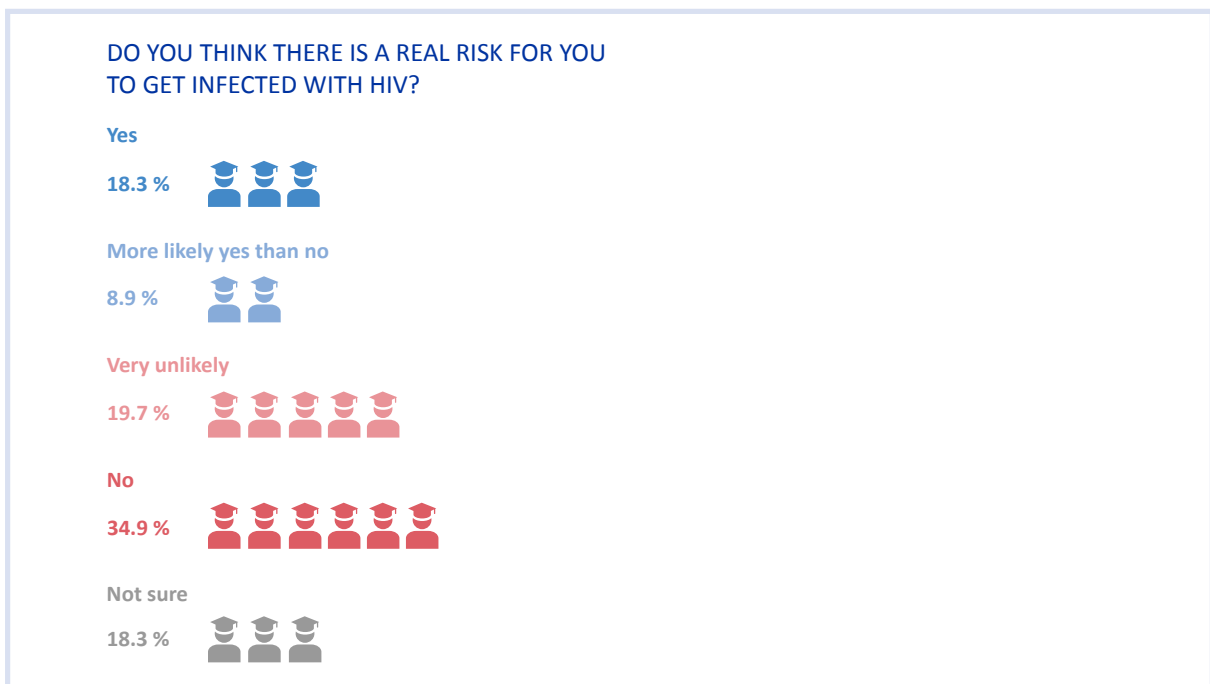


Figure 59. Perception of personal risk for HIV among international students

The assessment of the personal risk for HIV infection is gendered: The percentage of those who believe there is no such risks (answers “no” and “more likely ‘no’ than ‘yes’”) was higher among females (64.6%) than among males (53.4). At the same time, the percentage of those believe that the risk of HIV infection exists for them personally was almost the same: 26.3 per cent for females and 26.9 per cent for males (Figure 60).

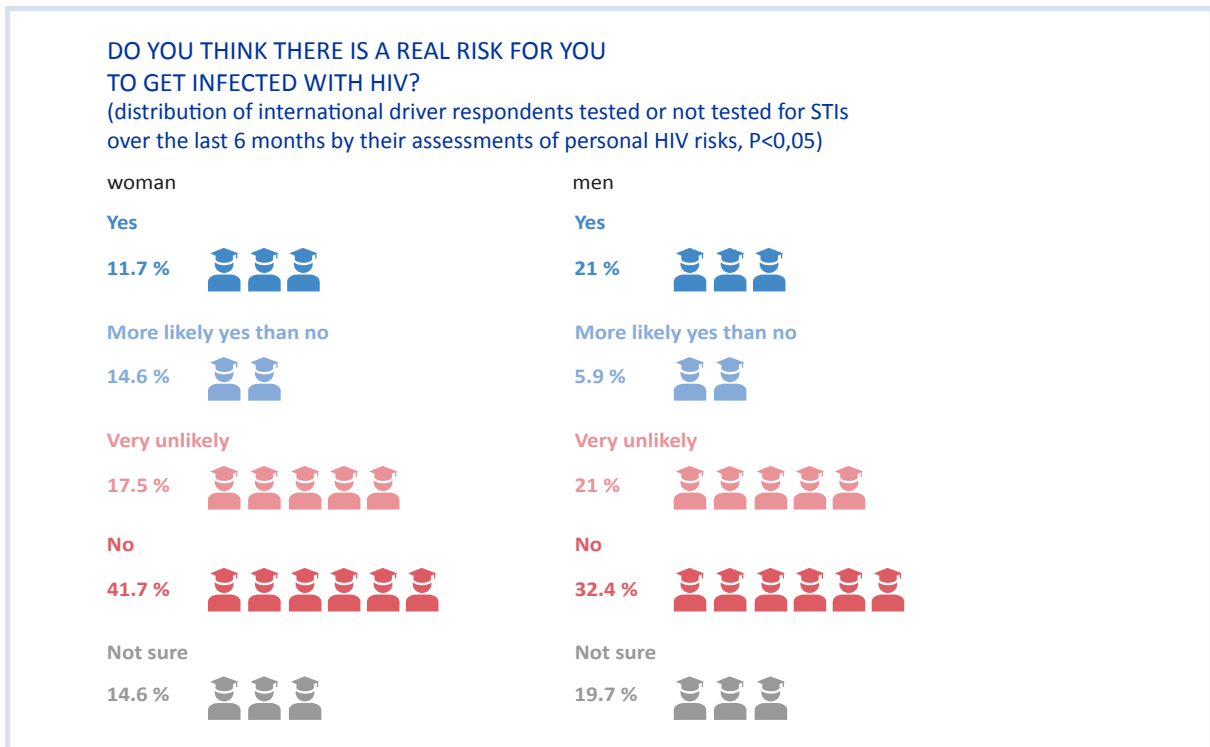


Figure 60. Perception of personal risk for HIV by gender among the international students

At the time of the survey, **fifty-eight per cent** of students believe that they **have a possibility to get tested for HIV**. Twenty-four per cent of respondents believe that they cannot have their HIV test done at the moment of the survey; 18 per cent were not sure or did not answer this question (Figure 61).

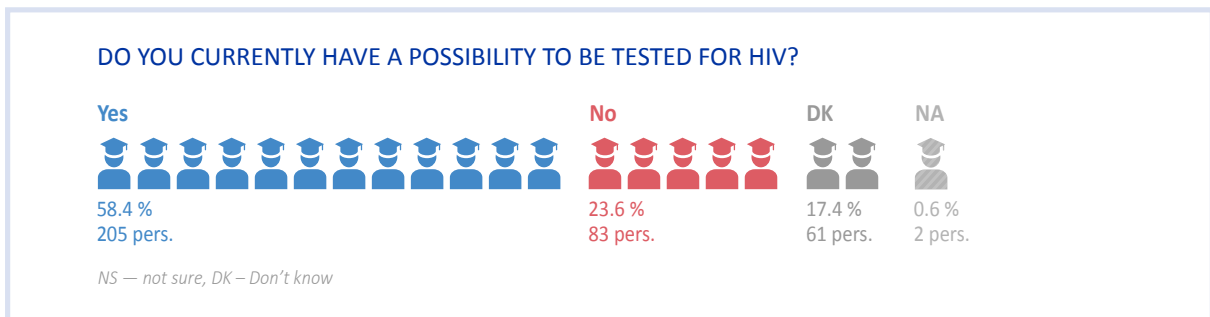


Figure 61. Perceived opportunity for getting tested for HIV among international students

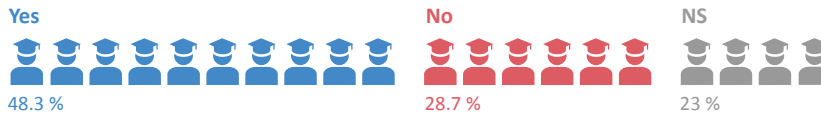
There is a correlation ($P < 0.05$) between the answer to the question “Do you currently have a possibility to be tested for HIV?” and the duration of students residing in the Republic of Belarus: with an increase in the duration of residence, the proportion of students who said they could get tested for HIV was increasing from 33.3 per cent (less than 3 months) to 63.5 per cent (for more than 1 year) (Figure 62).

CONTINGENCY TABLE “DO YOU CURRENTLY HAVE A POSSIBILITY TO BE TESTED FOR HIV?” “HOW LONG HAVE YOU BEEN LIVING IN BELARUS?” (P<0,05)

Over a year



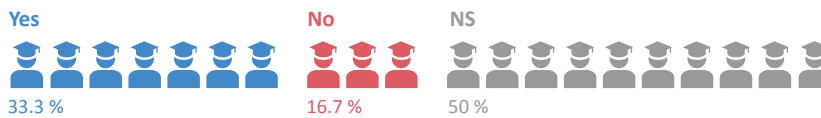
6-12 months



3-6 months



Less than 3 months



NS — not sure

Figure 62. Perceived opportunity for getting tested for HIV by international students' length of stay in Belarus

Sixty-one per cent of respondents have ever been tested for HIV. Ninety per cent of them knew the results of their tests. 34.6 per cent of them have been tested for HIV over the past six months (Figure 63).

HAVE YOU BEEN TESTED FOR HIV OVER THE LAST 6 MONTHS (% of those respondents who have ever been tested for HIV)

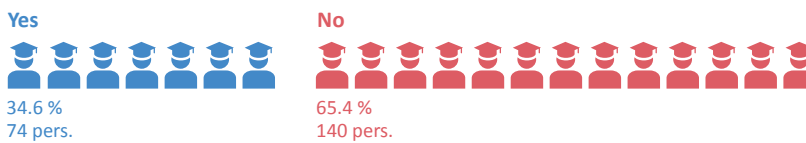


Figure 63. Distribution of international students according to history of having been tested for HIV over the last 6 months

In general, 21.1 per cent of all respondents have been tested for HIV over the last six months. Eighty-eight per cent of those respondents whose blood had been tested for HIV over the last six months know their results. Eighteen per cent of all students have been tested for HIV over the last six months and know their results. There are no significant differences in the level of HIV-related knowledge between the respondents who had been ever tested for HIV and the respondents who had not.

3.4. Focus groups results among international students

3.4.1. Sources of information about HIV, STIs and hepatitis C

Most focus group participants have **never thought about the threat of HIV, STIs and hepatitis C for them personally**. Some believe that the problem is irrelevant to them because they take safety measures or have no sexual contacts currently. Two respondents said that the problem is relevant to them because it is easier and cheaper to protect themselves now than to get treated for some disease in the future.

“HIV is sexually transmitted. Right now, I do not have a girlfriend, so at the moment this problem is not relevant to me. In the future, yes, this problem can affect me, but not now.”

“These diseases are dangerous, you can die, and I heard that you could die from HIV infection.”

“These problems are relevant for me because it is much easier to prevent it than to get sick, and to be treated.”

“These diseases will not affect me, because when I have sex, I use condoms.”

The **Internet and visual information at polyclinics are the main sources of information** about HIV. The participants did **not receive any information about STIs or hepatitis C**. Only one person heard about STIs from a friend who had had it.

“I read a book about HIV in hospital, I was in the hospital, and there were books about HIV and other infectious diseases. There was some information about HIV transmission.”

“I received the information at school, people from organizations came to us and explained things.”

“I saw information on the Internet.”

“There is information at information stands in the polyclinic, I was reading when I was waiting for my appointment.”

“I learned about STIs from a friend, he got infected and told me. It was in my home country.”

Despite the fact that the respondents have seen information somewhere (on the Internet, at the stands in polyclinics), they **did not remember the content**. Only one participant could name the ways of transmission of infections, while others said they did not remember.

“I remember that HIV is transmitted sexually, through drugs.”

If participants need information about HIV, STI or hepatitis C, they look it up on the **Internet, go to the doctor in the students' polyclinic or ask their dormitory teacher** where to go.

“I would look for information on the Internet.”

“One can see a doctor in the polyclinic.”

“I would ask the head of the dormitory where to go. She is like a second mother to us. She would tell me where to go to get help.”

Participants propose activities such as **classes on HIV, STIs and hepatitis C prevention at the preparatory course, as well as a brief refreshment course at the beginning of each academic year**,

to be carried out at the dormitory or during mentoring classes. Topics of interest to this group are ways of transmission, treatment, prevention measures, diagnostics, and locations where they can get help.

“How infection is spread, how not to get sick, what the treatment is, where to go for help.”

“The ways one can find out that he/she is infected.”

“What symptoms display themselves in case of infection.”

“The ways one gets infected.”

3.4.2. Behavioural risk

According to the participants, **drug use is not common among international students**; at least they had not noticed it among their friends. One student recalled that two years ago a student from Turkmenistan had been convicted for the distribution of narcotic substances. However, nobody had known about his addiction.

“In my home country, if you use drugs, you will get into jail immediately.”

“I do not know for sure, but I do not think students use drugs, not my friends at least.”

“There was a guy from Turkmenistan two years ago; he was sent to jail for drugs. Moreover, no one knew that he had been selling drugs, neither his friends nor fellow students. We did not even know whether he was on drugs or not.”

Alcohol consumption is not common among foreign students living in dormitories either, due to ‘no alcohol’ internal rules. However, on festive occasions or when they are visiting friends, a student might drink beer. Only one participant said he had ever drunk strong alcohol.

“Personally, I do not drink alcohol, it is prohibited by our religion, and it is not healthy.”

“I drink beer sometimes, but not in the dormitory.”

“It is forbidden in the dormitory, but I can take some beer on a festive occasion or when I visit my friends. When we have a party with my friends I can drink something stronger, I tried cognac twice.”

Medical procedures with blood at health care facilities, sexual contacts, transmission through insect bites (bugs, mosquitoes) are considered as risks of getting infected with HIV, hepatitis C or STIs.

“You can get HIV with a blood transfusion.”

“Multiple use of syringes in a hospital.”

“When they make injections.”

“One can get infected through sexual contacts; there might be some sexual contacts when no condom is used.”

“There used to be bedbugs here in the dormitory, they could bite one person and could transmit the disease to another person. Mosquitoes can bite as well.”

3.4.3. Preventive measures

Among the measures to prevent HIV, STIs and hepatitis C the respondents mentioned that it is **necessary to know the donor when getting a blood transfusion**; to **wash hands** more often (not to get hepatitis C), and to **use condoms** and contraceptives during sexual contacts (women should use contraceptives). The respondents could not respond to how protect themselves in medical facilities.

“You should use a condom during sexual intercourse with an unknown girl. Moreover, you should not have sex if there is no condom.”

“If you need a blood transfusion, you must know the person whose blood is taken.”

“Washing your hands and using contraceptives. However, it is not me, who should take pills.” (the answer was provided by a male)

All participants pointed out that **condoms are available everywhere**, they can be bought in pharmacies and stores. According to one respondent, it is safer to buy condoms in pharmacies, where storage conditions are more likely to be observed.

“Condoms are available here 100 per cent. You can buy them everywhere, but they are expensive, of course.”

“They (condoms) are sold in every store, even at bus stops.”

“There are condoms in stores and pharmacies. It is better to buy in pharmacies, as they might be of poor quality in a store. I was told so by doctors.”

3.4.4. HIV testing

All respondents had been **tested for HIV, STIs and hepatitis C when they entered Belarus** and then every time during an annual medical examination at the beginning of an academic year. When students arrive in Belarus for the first time, as a rule, they do not speak Russian, so they are being accompanied during the medical examination by a student who speaks Russian and translates the instructions of the medical personnel. No student mentioned pre-test counselling or receiving the results of their tests.

“I entered the nurse’s office, she took the blood, and I left. Later the results were sent to the doctor. I was not informed about the results.”

“When I was tested for HIV for the first time, I did not speak Russian, so my friend translated for me. The nurse asked me to take off my shirt, took the blood and after a while told me to throw out the cotton wool to the bin.”

None of the participants knew that it was possible to do HIV test at home with the help of a saliva test, which can be purchased data drugstore.

3.5. Results of the survey of migrants residing and working in the Republic of Belarus

Practically all respondents included in the sample are Ukrainian citizens who fled the conflict zone. Ninety per cent of them spent, at least 12 months in Belarus residing in urban areas (95 %). Among the respondents, 42 per cent report having financial problems, while 47 per cent consider their financial standing as “average”. The people surveyed are relatively young; with 45 per cent under 35 years of age, and 29 per cent between mid-thirties and mid-forties. They are well-educated, with 60 per cent having secondary or vocational school completed, while 37 per cent have University diploma (for details see Annex 3).

SUMMARY

1. **The level of migrants’ knowledge on the HIV test window and the stages of the disease is not high.** Less than half of the migrants interviewed (46%) know that AIDS is the last stage of HIV, while 24.8 per cent believe that HIV and AIDS are the same diseases; 12.3 per cent consider HIV and AIDS to be two different diseases and 16.9 per cent are undecided. The level of migrants’ knowledge on HIV test window period is not very high either. Only 32.2 per cent of respondents know that HIV can be detected in the blood three months after infection, and more than a third (34%) gave no answer. Migrants were poorly informed about the potential of HIV antiretroviral therapy. Thus, only less than half (43.6%) of respondents know that an HIV-positive person can maintain good health for many years if he/she takes special medicines (antiretroviral therapy). One third of respondents were undecided.
2. **The target group revealed a low level of knowledge both on general issues of HIV infection (stages of the disease, HIV test window period, etc.), and on the ways of HIV transmission.** Depending on the question, between 50.6 per cent and 84 per cent were able to identify the modes of transmission correctly. This indicator was the highest for the question “*Can people reduce the risk of HIV transmission by using condoms?*” (84% of the respondents answered correctly), and the lowest for the question “*Can a healthy-looking person have HIV?*” (only 50.6% answered correctly). 77.3 per cent of respondents know that it is possible to become infected with HIV while getting a tattoo, a manicure, or a shave with non-sterile tools. Eighty per cent of respondents agreed that staying faithful to one uninfected trustworthy sexual partner can reduce the risk of HIV transmission. The level of migrants’ awareness about misconceptions of HIV transmission is also low. Only 51.5 per cent of respondents know that HIV cannot be transmitted by mosquito bites, whereas 21.5 per cent believe it could, and 27 per cent of respondents were undecided. Forty-five per cent of those interviewed know that HIV is not transmitted by sharing utensils and household items (sharing a bath, a pool, a toilet with an HIV-infected person); 22.7 per cent believed it is; while almost one-third of respondents (32.5%) were undecided. Generally, the migrants’ knowledge was fragmentary, since the proportion of migrants who correctly answered all the questions about the ways of HIV transmission was only 17.8 per cent.
3. **The majority of migrants have been exposed to information on HIV, with television programmes and advertisements ranging among the most important sources.** Eighty-six per cent of migrants received information about HIV/AIDS. Respondents received information about HIV from various sources. The main sources of information were television programmes and advertisements (mentioned by 54.5% of respondents who received information about HIV/AIDS), out-of-home advertising (51.3%) and the Internet (51.3%). Thirty-five per cent of migrants surveyed received such information from special

literature, leaflets, booklets; 30.5 per cent from medical personnel at medical centres; 19 per cent from friends.

Of the total number of respondents who received information about HIV/AIDS, 23.3 per cent of respondents received such information mainly in Belarus; 49.5 per cent both in Belarus and in another country, 23.3 per cent mainly in another country; 3.9 per cent did not answer. Thus, 72.8 per cent of migrants surveyed received information about HIV mainly or partly in Belarus.

4. **The majority of migrants are aware of sexually transmitted infections (STIs), however the level of knowledge about STIs in the target group can be assessed as low.** Ninety per cent of migrants noted that they are aware of the existence of sexually transmitted infections. 8.6 per cent of respondents indicated that they do not know about such infections, 1.8 per cent did not answer. Of the total number of respondents who reported being aware about STIs, 37.3 per cent have been tested for sexually transmitted infections (syphilis, gonorrhoea, herpes, chlamydia, etc.) over the last six months. 33.4 per cent of all respondents have been tested for sexually transmitted infections over the last six months. The majority of respondents (84.9% of the total number of the respondents who reported being aware of the STIs) believe that it is possible to avoid STIs during sexual intercourse with a non-regular partner by always using a condom. Twenty-four per cent said that it is possible to avoid infection by treating reproductive organs with disinfectants (miramistin, chlorhexidine) after unprotected sexual intercourse.
5. **The level of awareness about hepatitis C and the transmission of the disease is not high among migrants, and less than one quarter knows all transmission modes correctly.** Seventy-eight per cent of migrants are aware of the existence of hepatitis C, 21.2 per cent indicated that they do not know about this infection, and 0.9 per cent failed to provide an answer. Of the total number of respondents who knew about hepatitis C, 17.3 per cent, (or 13.5% of all respondents), have been tested for hepatitis C over the last six months.

When listing the ways of transmission of hepatitis C, 81.5 per cent (*of all respondents who knew about the existence of hepatitis C*) mentioned transmission by shared use of instruments (syringe, needle, etc.) to inject a drug; 66.5 per cent while getting a tattoo, a manicure, or a shave with non-sterile tools; and 54.3% via sexual intercourse without a condom. At the same time, respondents believe in some misconceptions about the transmission of hepatitis C. Thus, 13.4 per cent of the respondents believe that hepatitis is spread via airborne transmission; 11.2 per cent with mosquito bites; 9.4 per cent by eating with dirty hands. Overall, 23.9 per cent of all migrants interviewed correctly named all actual transmission modes of hepatitis C.

6. **More than three-quarter of those migrants, who had sexual intercourse with a non-regular sexual partner, had more than one partner, on average three. A bit more than half of them used a condom during their last intercourse with a non-regular partner, less than one third always uses a condom with a non-regular sexual partner.** Of the number of migrants who reported ever having sexual intercourse, 82.3 per cent (85.9% of males and 78.6% of females), or 71.5 per cent of the total number of respondents, have had sexual intercourse over the past 12 months. Thirty-eight per cent of respondents have had sex with a non-regular sexual partner over the last 12 months. Seventy-five per cent of respondents who have had sexual intercourse with a non-regular sexual partner over the last 12 months had contacts with more than one partner. Those who reported having sex with more than one

non-regular partner over the last 12 months, on average have had three different sexual partners (a median number).

Fifty-two per cent of respondents who have had sex with a non-regular partner used a condom during their last intercourse with a non-regular partner. Thirty-three per cent of respondents always used a condom with a non-regular sexual partner. Non-use of condoms with non-regular partners was explained by several reasons such as: “I trust my partner” (30.7%), “Condoms are not always available when needed” (28.4%), and “Condoms reduce sexual pleasure” (26.1%). In general, the rates of condom use with non-regular partners observed among the respondents are indicative of quite a high level of behavioural sexual risk in this target group.

7. **More than 10 per cent of those, who have a regular sexual partner, also have sexual contacts with non-regular sexual partners and only 37 per cent of those used a condom with a non-regular sexual partner.** Sixty-eight per cent of the respondents have a regular sexual partner. Twelve per cent of the respondents (27 persons) had sexual intercourse with both regular and non-regular partners over the last 12 months. Fifty-six per cent of such respondents used a condom in the last sexual intercourse with a non-regular partner. Thirty-seven per cent of the respondents who have had sexual intercourse with regular and non-regular partners over the past 12 months always used a condom with a non-regular sexual partner. Thus, regular partners of persons who have sex with both regular and non-regular partners can be also considered at risk for HIV.
8. **Transactional sex and remunerating the partner for sex is not uncommon among migrants of both genders, and condom use is low in this situation.** Of all respondents who had sexual intercourse over the last 12 months, 6 per cent (7 males and 7 female) reported engagement in transactional sex over the last 12 months; 1.3 per cent of respondents did not answer this question. Condoms were used by 6 persons out of 14 (42.9%) during the last transactional sexual intercourse. Of all respondents who had had sexual intercourse over the last 12 months, 8.6 per cent (15 men and 5 women) purchased sexual services (remunerated their partner for sex); 2.1 per cent of respondents did not answer this question. Five persons out of 20 (25%) used condoms during the last purchased sexual intercourse. Of all respondents who had regular partners, 3.8 per cent have purchased sexual services over the last 12 months, with 3 out of 6 persons reporting the use of condoms during last commercial sexual intercourse. Therefore, further exploration of the issues related to commercial sex services needs to be differentiated by gender.
9. **Migrants’ evaluation of their personal risk of HIV infection is controversial with one quarter seeing a risk, and more than half of respondents believing that there is no risk for them.** Twenty-five per cent believe that the risk to become HIV-infected is real for them (12.4% answered “yes”, 12.1% “more likely ‘yes’ than ‘no’”). More than half of the respondents (54.8%) believe that there is no risk for them to become HIV-infected (28.2%) or that it is “very unlikely” (26.6%). Twenty-one per cent of respondents were undecided. In general, women provide more definite answers to this question – thus, 32 per cent of men (compared to only 10.6% of women) were undecided in assessing their risk of HIV infection.
10. **Alcohol consumption is common among more than half of the migrants, with higher percentages among men, and more than 10 per cent have ever used non-injection drugs, whereas 3.6 per cent reported ever having injected drugs.** Fifty-six per cent of migrants consumed alcohol during the last month. Alcohol was used by 68.7 per cent of men and

45.3 per cent of women. Strong spirits (vodka, cognac, whisky, moonshine) are the most common alcoholic beverages: 49.2 per cent of all respondents who have consumed alcohol in the last month drank strong spirits. Thirty-four per cent consumed beer, and 32.3 per cent wine. Twenty-one per cent drank low-alcohol beverages. 11.3 per cent of migrants reported having ever used non-injection drugs (smoking blends, “weed”, pills, solutions, powders). Four per cent of respondents said that they had used injection drugs (once or several times). Thirteen per cent of respondents did not answer this question. Since the level of drug use was identified as quite high in this target group, further in-depth research will be needed.

11. **Only 62.9 per cent of migrants know that they can get tested for HIV, and 65 per cent have ever been tested for HIV in the last six months.** Sixty-three per cent of migrants know that they had a possibility to get tested for HIV at the time of the survey. Twelve per cent of respondents believe that they could not be tested; 31.5 per cent responded that they did not know or did not answer this question. 65 per cent of respondents have ever been tested for HIV. Seventy-five per cent out of them know the results of their tests. Twenty-eight per cent of them have been tested for HIV in the past six months. In general, 18.1 per cent of all the respondents have been tested for HIV over the last six months. Ninety-eight per cent of respondents who have been tested for HIV over the last six months know their results. Eighteen per cent of all respondents have been tested for HIV during the last six months and know their results. There were no significant differences revealed between the respondents who had been ever tested for HIV and the respondents who had not and the level of their HIV related knowledge.

3.5.1. HIV infection awareness

Less than a half of the migrants **know that AIDS is the last stage of HIV infection (46%)**. Twenty-five per cent of respondents believe that HIV infection and AIDS are the same diseases; 12.3 per cent considered HIV and AIDS to be two different diseases. 16.9 per cent of the respondents failed to answer this question (Figure 64).

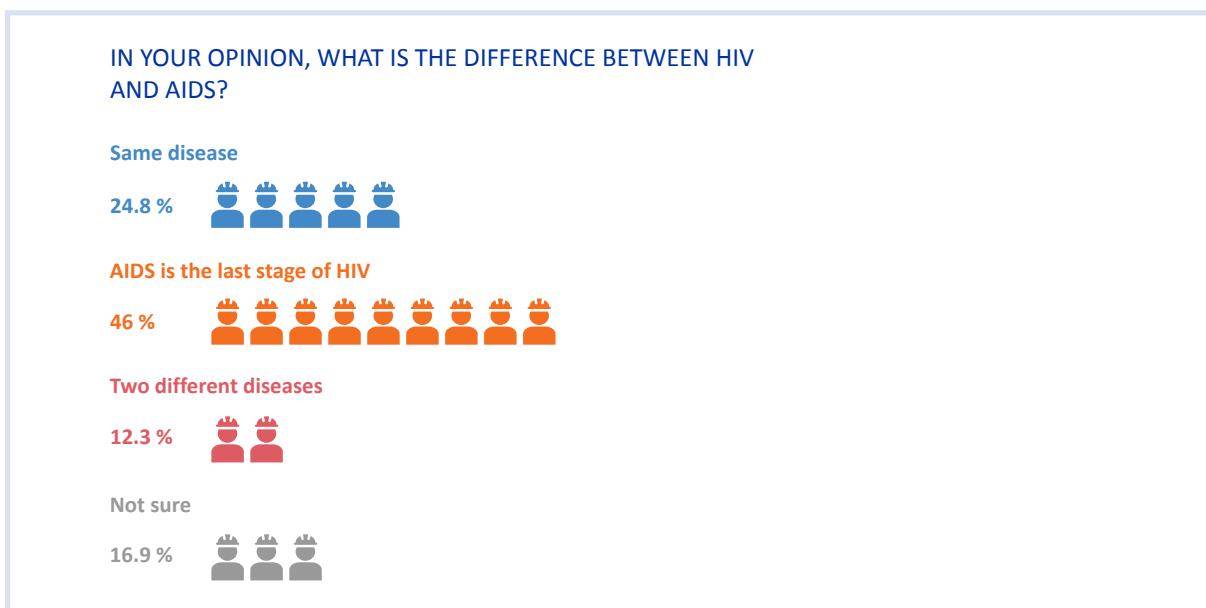


Figure 64. Percentage distribution of the migrants' responses whether HIV is different from AIDS

The level of migrants' knowledge on the HIV test window period is low. Only 32.2 per cent of respondents know that an HIV infection could be detected in blood three months after infection, more than a third (34%) failed to answer this question (Figure 65).

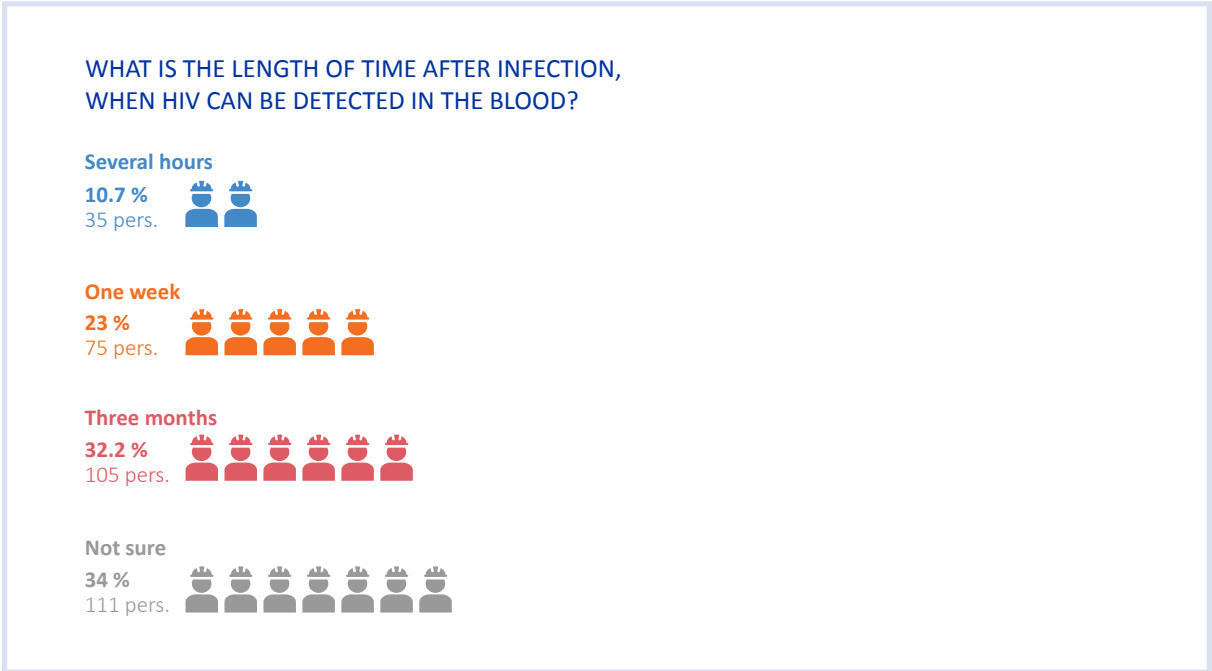


Figure 65. Percentage distribution of the migrants' responses to the question of when HIV can be detected in the blood

Migrants are poorly informed about the potential of antiretroviral therapy (ART) for HIV. Only less than half of the respondents (43.6%) know that an HIV-positive person can maintain good health for many years if he or she receives ART. Thirty-three per cent of respondents failed to answer this question (Figure 66).

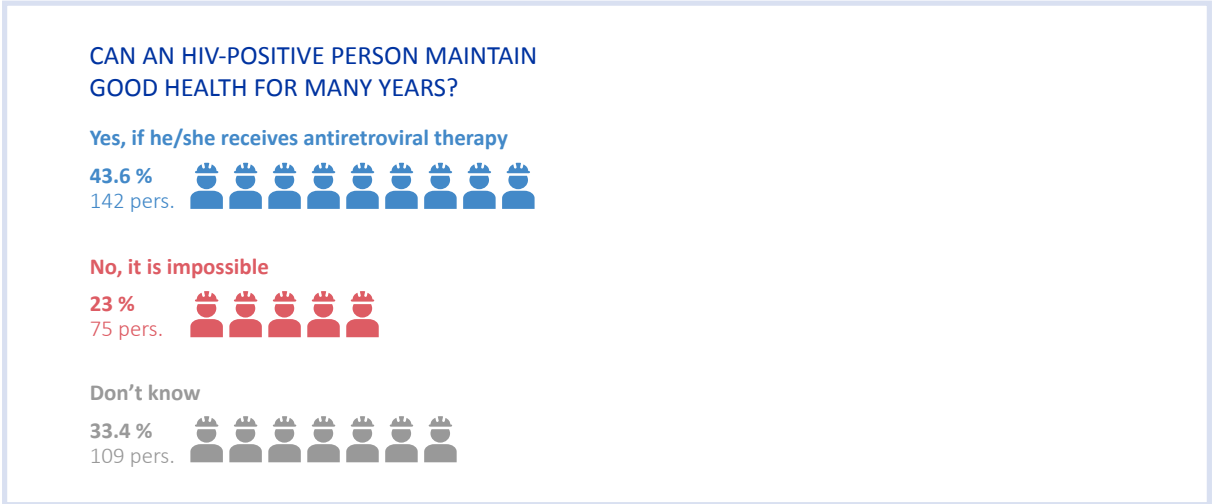


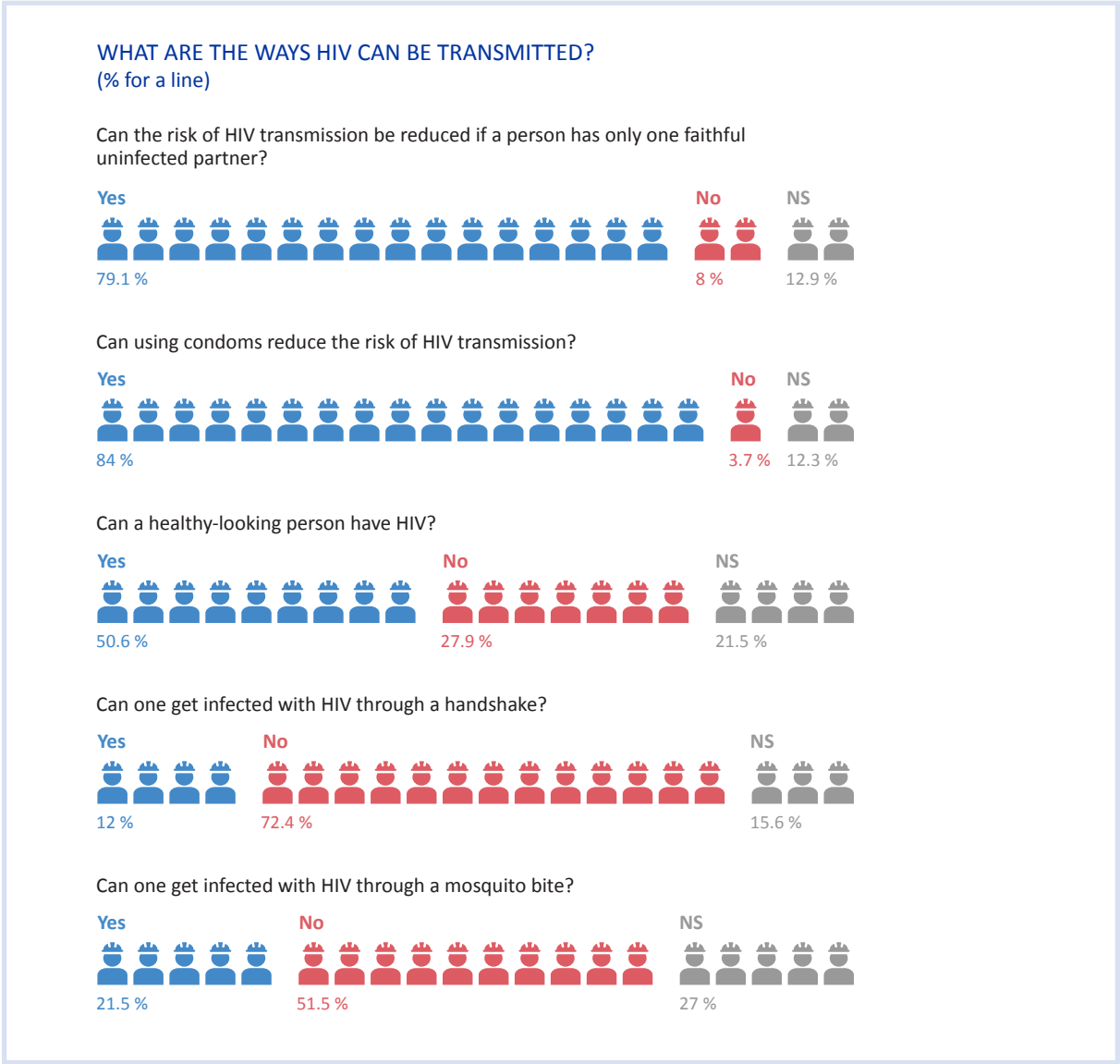
Figure 66. Distribution of migrants' answers to the question on the health condition of PLHIV

While most respondents reported being aware of the main ways of HIV transmission, the level of knowledge on the ways of HIV transmission cannot be considered high. Thus, the level of knowledge on issues related to existing ways of HIV transmission ranges from 50.6 per cent to 84 per cent. This indicator was the highest for the question "Can people reduce the risk of HIV transmission by

using condoms?” (84% of respondents answered correctly), and the lowest – for the question “Can a healthy-looking person have HIV?” (only 50.6% of respondents answered correctly). Eighty-four per cent of respondents believe that it was possible to reduce the risk of HIV transmission by using condoms. Seventy-seven per cent of respondents know that it was possible to get infected with HIV while getting a tattoo, a manicure, or a shave with non-sterile tools. Only 79.1 per cent of respondents agreed that it is possible to reduce the risk of HIV transmission by staying faithful to one uninfected trustworthy partner.

The level of migrants’ awareness of false HIV transmission modes is also low. Thus,

- Only 51.5 per cent know that HIV is not transmitted through a mosquito bite; whereas 21.5 per cent believe that one could be infected with HIV this way; 27 per cent of respondents failed to answer the question.
- 44.8 per cent of respondents know that HIV is not transmitted through household contacts (sharing a bath, a pool, a toilet with an HIV-infected person); 22.7 per cent believe it is, and almost a third of respondents (32.5%) failed to answer this question (Figure 67).



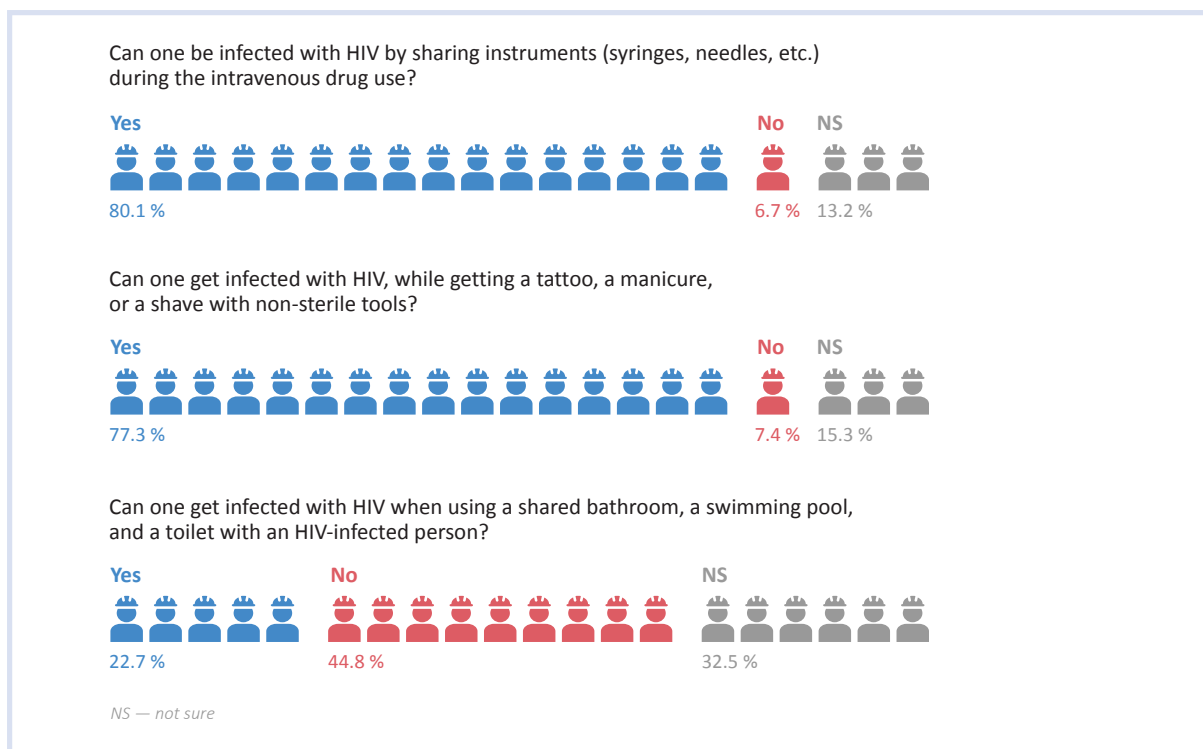


Figure 67. Knowledge of migrants regarding HIV transmission

In general, 29.1 per cent of respondents know how to prevent sexual transmission of HIV, and at the same time reject main misconceptions related to HIV transmission (for the 5 questions below):

- “Can the risk of HIV transmission be reduced if a person has only one faithful uninfected partner?”
- “Can the risk of HIV transmission be reduced by using condoms?”
- “Can a healthy-looking person have HIV?”
- “Can one get infected with HIV through a handshake?”
- “Can one get infected with HIV through a mosquito bite?”

Eighteen per cent of respondents answered all the questions about modes of HIV transmission correctly.

Eighty-six per cent of migrants received information about HIV/AIDS. The main sources of information on HIV/AIDS for migrants were television programmes and advertising (this source was indicated by 54.5% of respondents who received information about HIV/AIDS), out-of-home advertising (51.3%) and Internet (51.3%). Thirty-five per cent of respondents received information from special literature, leaflets, and booklets. Thirty-one per cent of respondents received information about HIV from medical personnel in medical centres. Nineteen per cent of the respondents received information from their friends (Figure 68).

FROM WHAT SOURCES DID YOU RECEIVE INFORMATION ABOUT HIV/AIDS?
 (% of all the respondents who received information on HIV/AIDS; several response options could be selected)

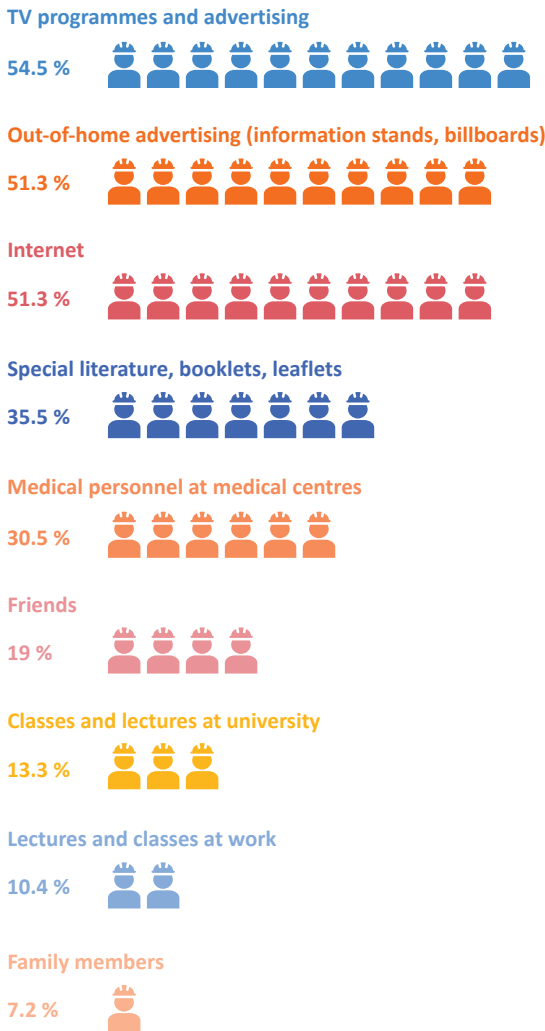
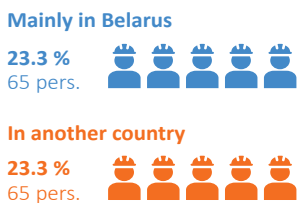


Figure 68. Sources of information about HIV/AIDS among migrant respondents

Twenty-three per cent of respondents (of those respondents who received information about HIV/AIDS) received information about HIV mainly in Belarus; 49.5 per cent both in Belarus and in another country, 23.3 per cent mainly in another country; 3.9 per cent failed to answer this question (Figure 69).

WHERE DID YOU RECEIVE SUCH INFORMATION?



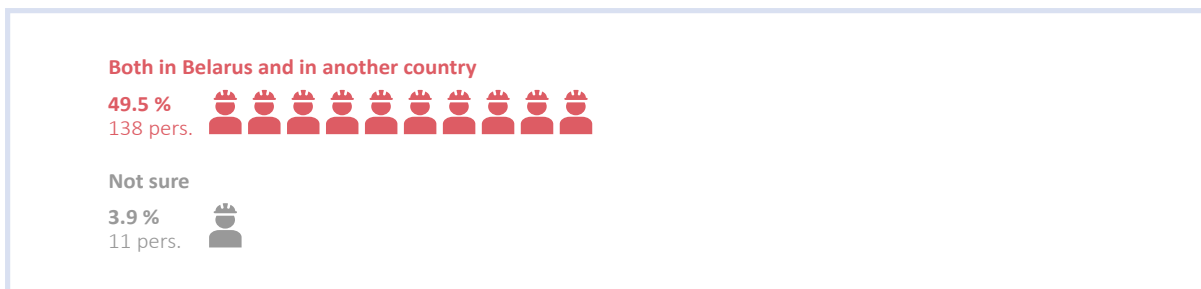


Figure 69. Distribution of responses on where migrants received HIV-related information

Thus, 72.8 per cent of migrants received information about HIV mainly or partly in Belarus.

3.5.2. Awareness about sexually transmitted infections (STIs)

Ninety per cent of respondents reported being **aware of the existence of sexually transmitted infections**, whereas 8.6 per cent of respondents indicated that they do not know about such infections (Figure 70).

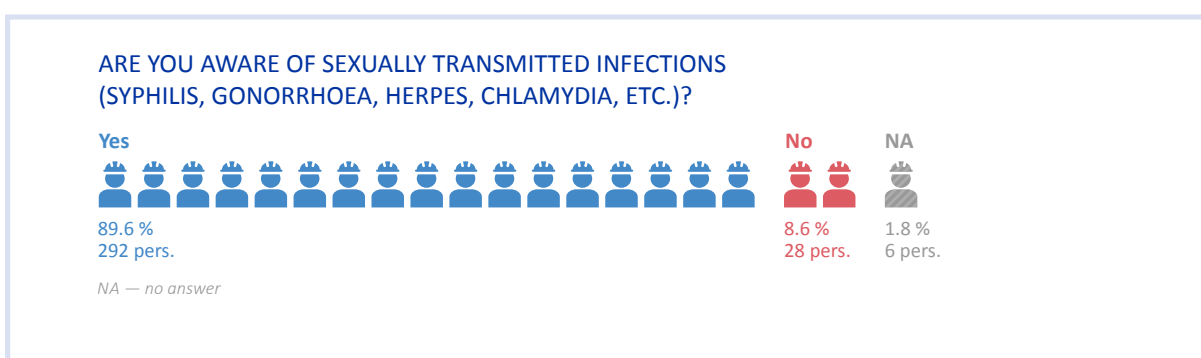


Figure 70. Distribution of migrants' awareness of sexually-transmitted diseases

Thirty-seven per cent of respondents (of those respondents who knew about STIs) **have been tested for sexually transmitted infections (syphilis, gonorrhoea, herpes, chlamydia, etc.) over the past 6 months** (Figure 71).

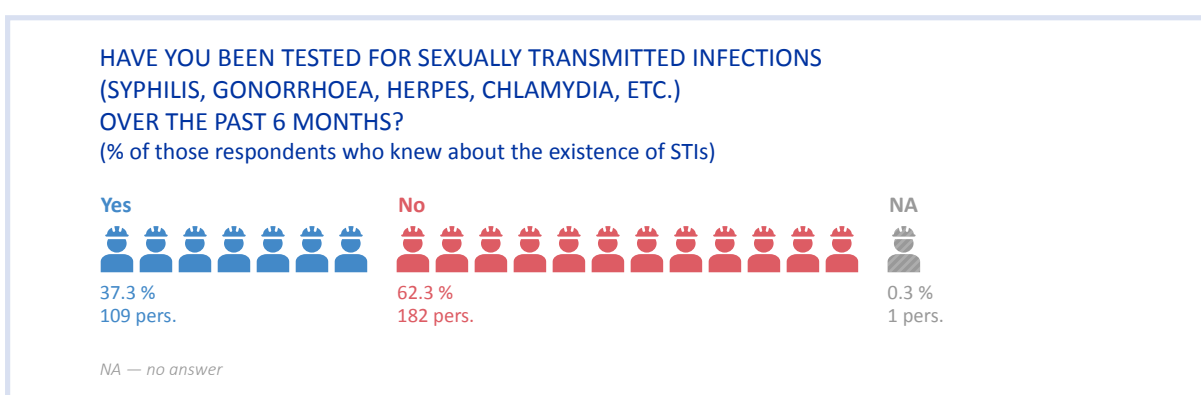


Figure 71. Distribution of migrants according to past medical history of having been tested for sexually-transmitted diseases over the last six months

Thirty-three per cent of all migrants had been tested for sexually transmitted infections over the last 6 months. The majority of respondents (84.9%) (of those who know about the existence of STIs) believe that it is possible to avoid being infected with STIs during sexual intercourse with a non-regular partner by always using a condom. Twenty-four per cent believe that treating reproductive organs with disinfectants (miramistin, chlorhexidine) after unprotected sexual intercourse makes it possible to avoid infection (Figure 72).

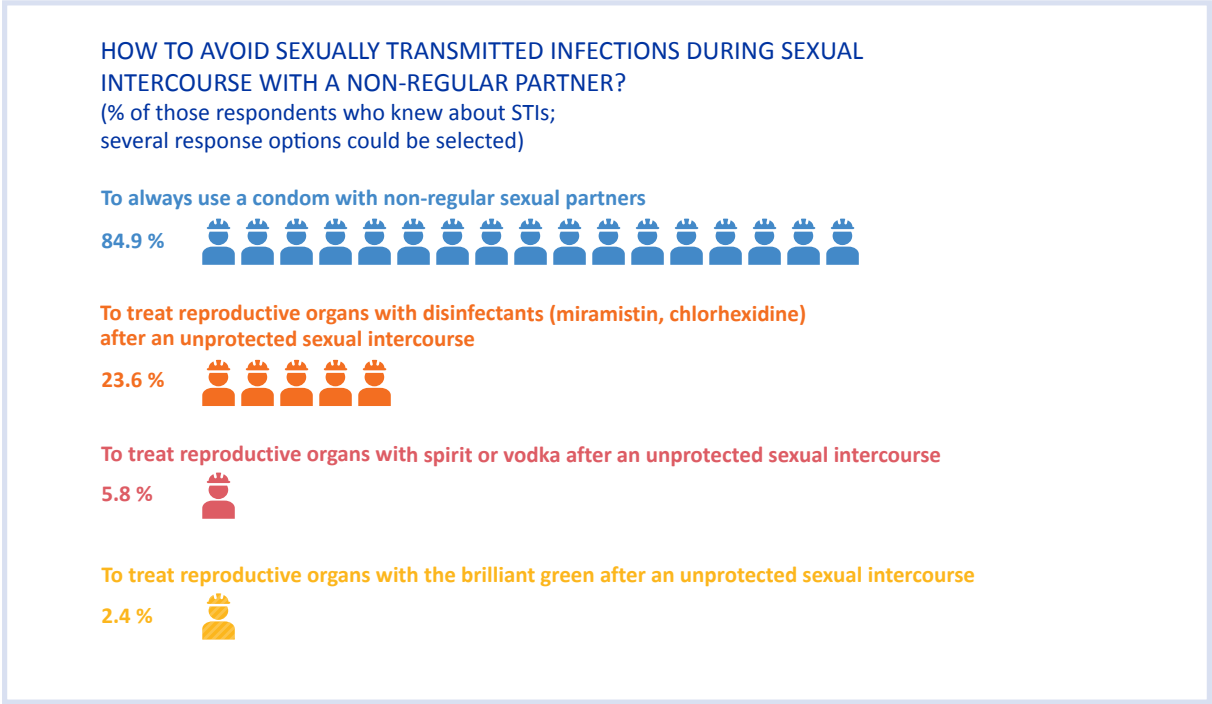


Figure 72. Methods to avoid sexually transmitted infections according to migrants

3.5.3. Awareness about hepatitis

Seventy-eight per cent of migrants are aware of the existence of hepatitis C, 21.2 per cent of the respondents noted that they did not know about this infection, 0.9 per cent failed to answer the question (Figure 73).

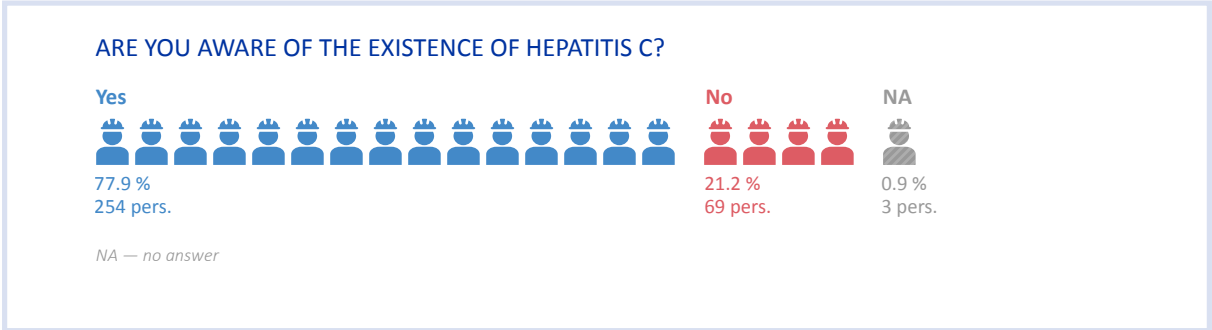


Figure 73. Distribution of migrants according to awareness of hepatitis C

Seventeen per cent of the respondents who knew about hepatitis C have been tested for hepatitis C over the last six months (Figure 74).

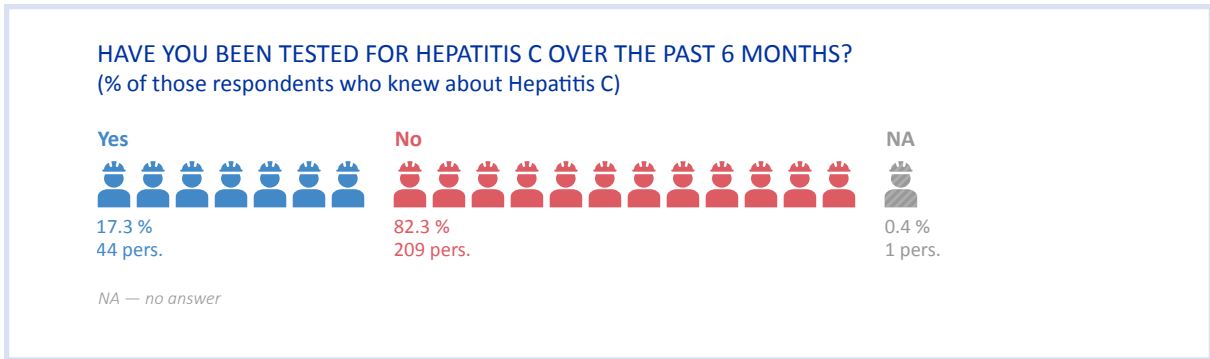


Figure 74. Distribution of migrants according to past medical history of having been tested for hepatitis C over the last 6 months

Thirteen per cent of the total number of migrants interviewed have been tested for hepatitis C over the last six months. The level of knowledge of the respondents **about the ways of transmission of hepatitis C is not high**. Overall, **23.9 per cent** of all the migrants interviewed **correctly named the actual ways of transmission of hepatitis C**. Thus, when listing the ways hepatitis C was transmitted:

- 81.5 per cent of respondents mentioned that hepatitis C could be transmitted through sharing instruments (syringes, needles, etc.) when injecting a drug (*of those respondents who knew about the existence of hepatitis C*);
- 66.5 per cent know that hepatitis C could be transmitted during tattooing, manicure or shaving with non-sterile instruments;
- 54.3 per cent know that hepatitis C can be transmitted through sexual intercourse without a condom.

At the same time, false routes of hepatitis C transmission were also mentioned:

- 13.4 per cent of respondents believe that hepatitis spreads via airborne transmission;
- 11.2 per cent through a mosquito bite;
- 9.4 per cent by eating with dirty hands (Figure 75).

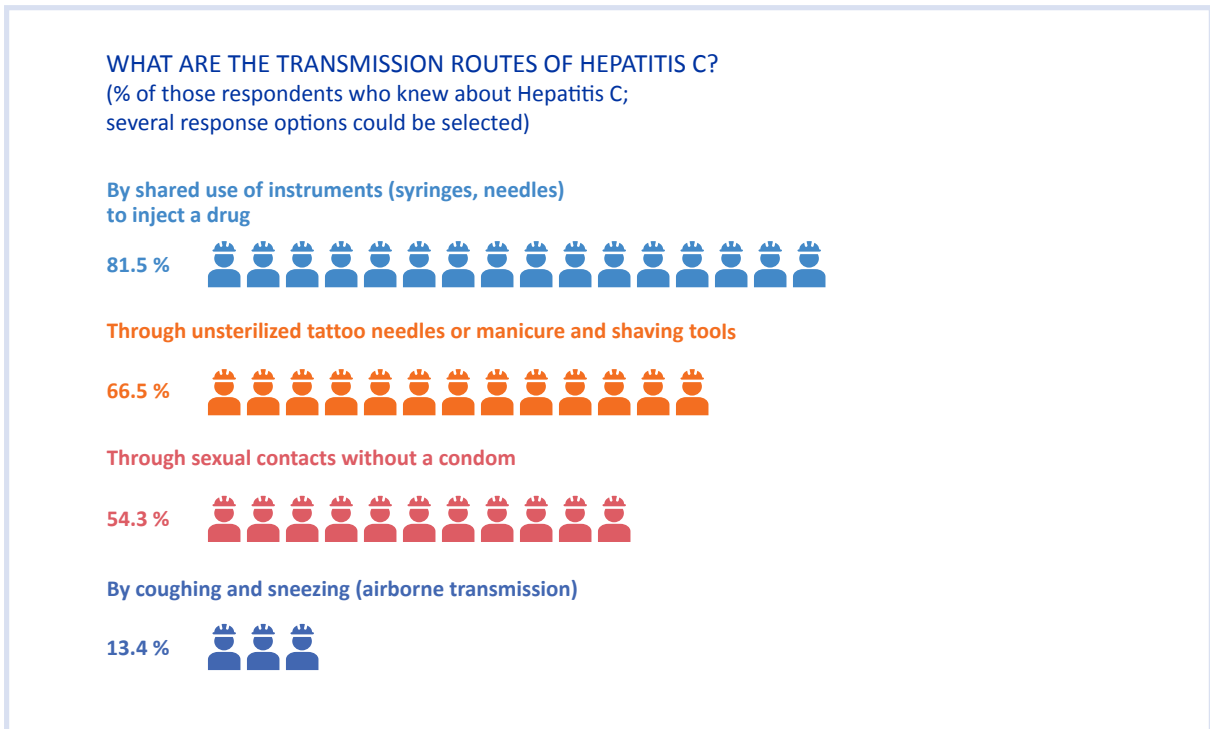




Figure 75. Awareness of transmission routes for hepatitis C among migrants

3.5.4. Sexual behavioural risk

Eighty-seven per cent of migrants reported having ever had a sexual contact (90% males and 84.3% females).

Out of these, 82.3 per cent (85.9% males and 78.6% females), or 71.5 per cent of the total number of respondents, have had sex over the past 12 months.⁷

Thirty-eight per cent of respondents have had sexual contacts with a non-regular sexual partner over the last 12 months (Figure 76).

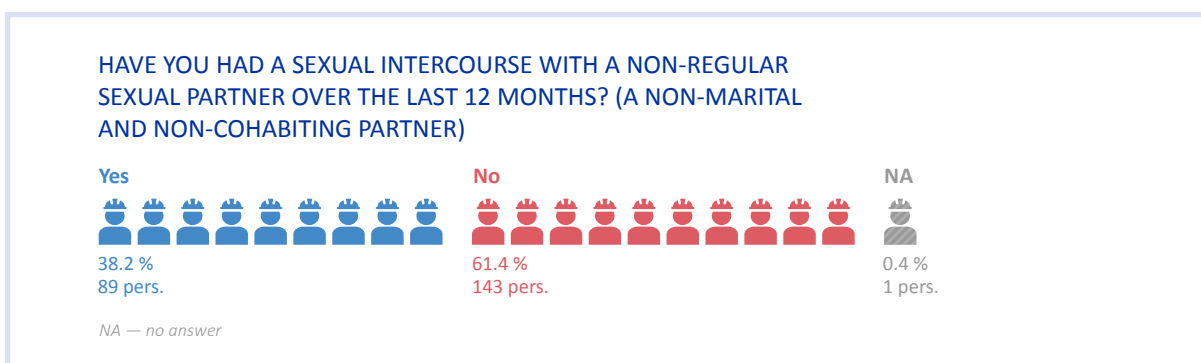


Figure 76. Distribution of migrants according to history of having a sexual intercourse with a non-regular partner over the last 12 months

There is a statistically significant correlation between the gender of respondents and reporting sex with a non-regular partner over the last 12 months ($P < 0.001$): 53.4 per cent of males (62 persons) and 23.7 per cent of females (27 persons) have had sex with a non-regular partner.⁸

Seventy-five per cent of respondents who have had sex with a non-regular partner over the last 12 months have had contacts with more than one partner (Figure 77).

⁷ The figures provided further in this section are calculated for the respondents who have ever reported having sexual contacts and having sex over the last 12 months.

⁸ Further indicators of behavioural sexual risk with a non-regular partner are calculated as a whole, without differentiation by gender, since statistical sex correlations would not give a correct result due to the small number of women who had non-regular sexual partners.

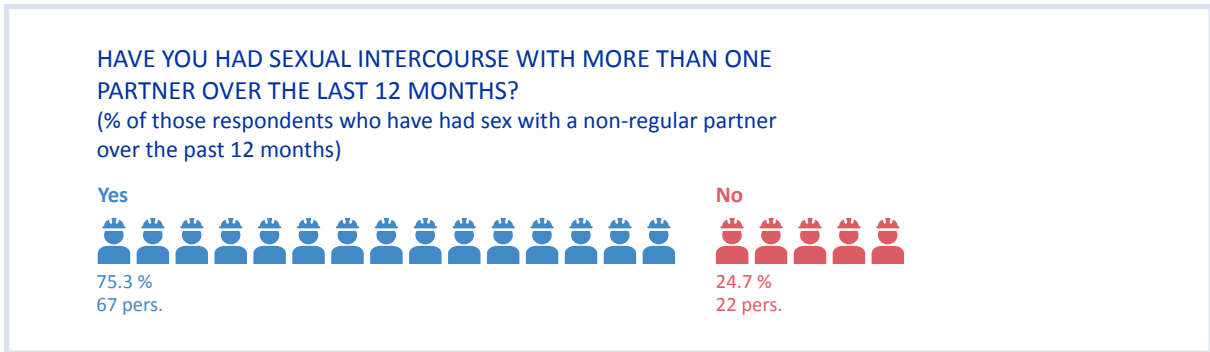


Figure 77. Distribution of migrants according to their history of having more than one sexual partner over the last 12 months

Those who have reported having sex with more than one non-regular partner over the past 12 months have had, on average, three different sexual partners (median number). Fifty-two per cent of respondents who have had sex with a non-regular partner used a condom during their last intercourse with a non-regular partner (Figure 78).

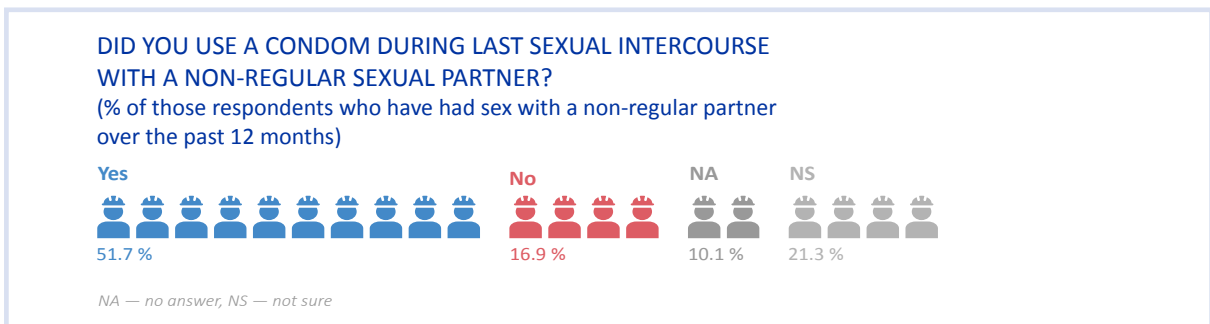
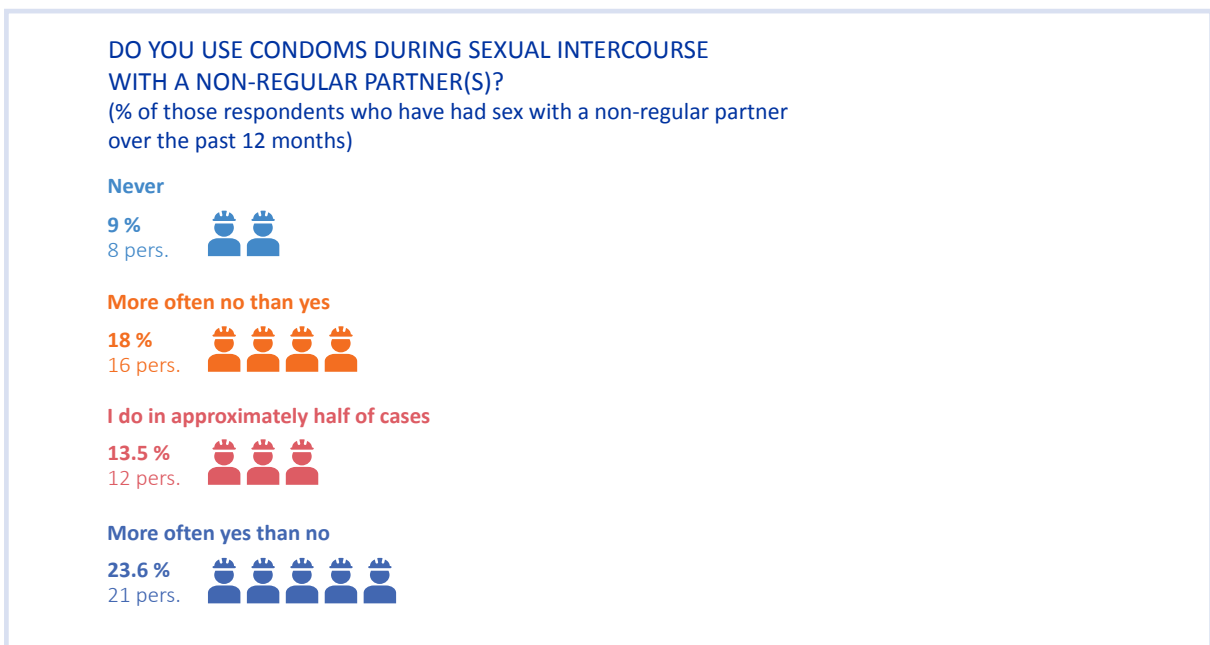


Figure 78. Condom usage among migrants during last sexual intercourse with a non-regular sexual partner

Thirty-three per cent of respondents said they always used a condom with a non-regular sexual partner (Figure 79).



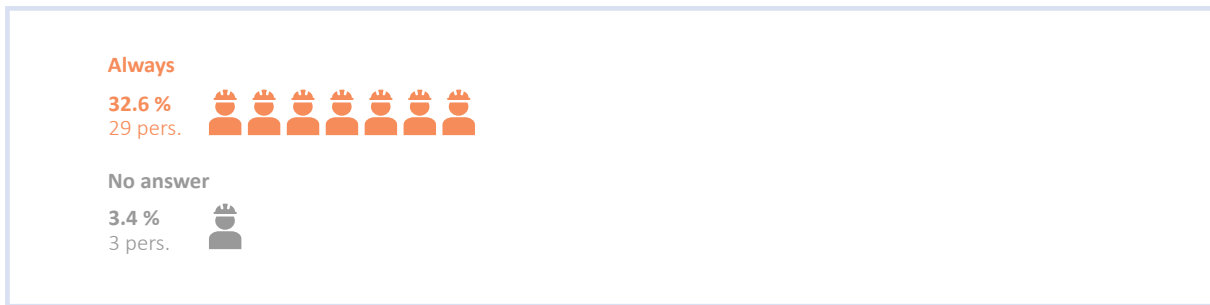


Figure 79. Frequency of condom use during sexual contacts with a non-regular partner as claimed by migrants

Non-use of condoms with non-regular partners was explained by several reasons, such as: “I trust my partner” (30.7%), “Condoms are not always available when needed” (28.4%), “Condoms reduce sexual pleasure” (26.1%) (Figure 80).

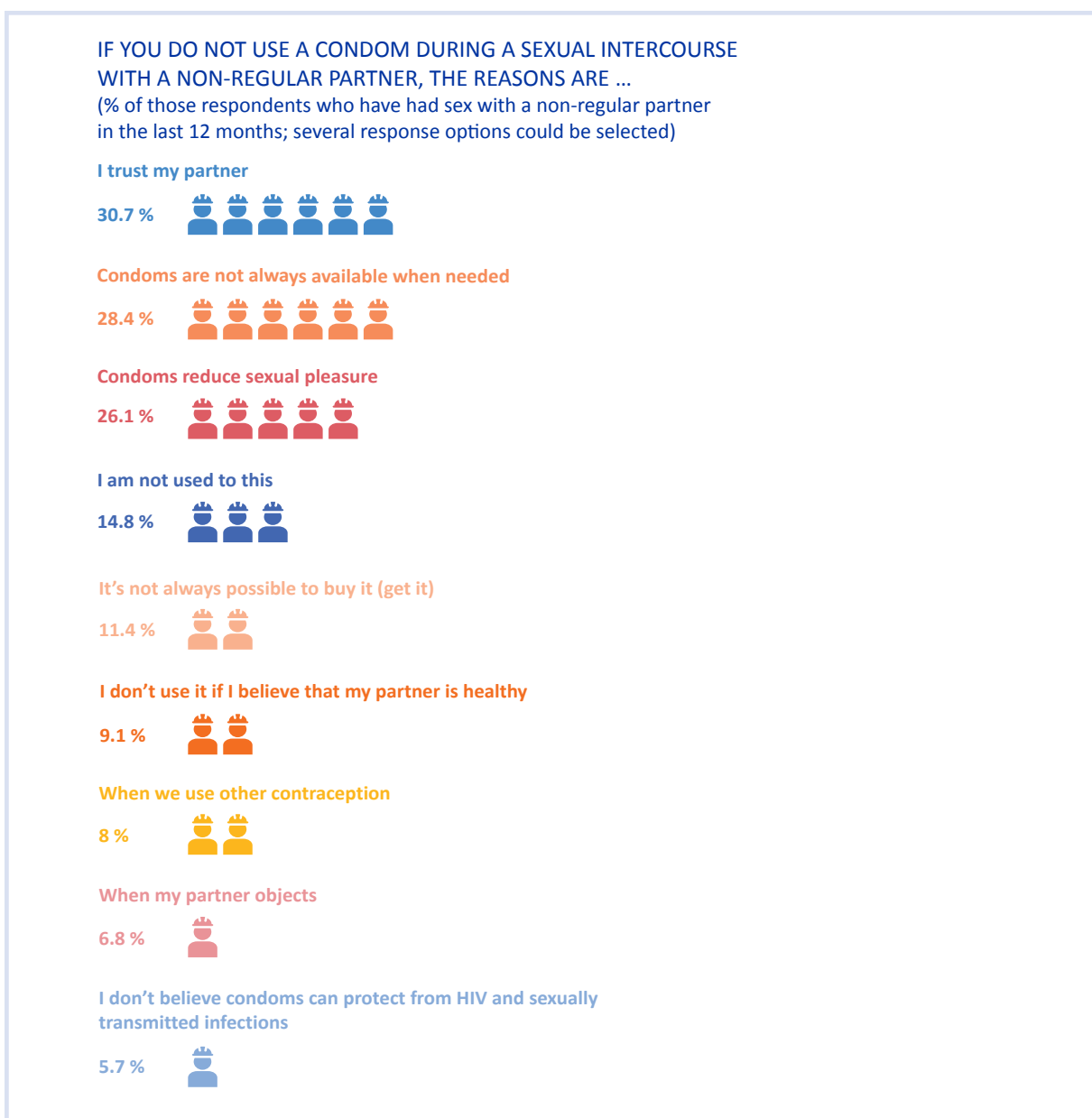


Figure 80. Reasons for not using condom with a non-regular partner according to migrants

Sixty-eight per cent of respondents had a regular sexual partner (Figure 81).

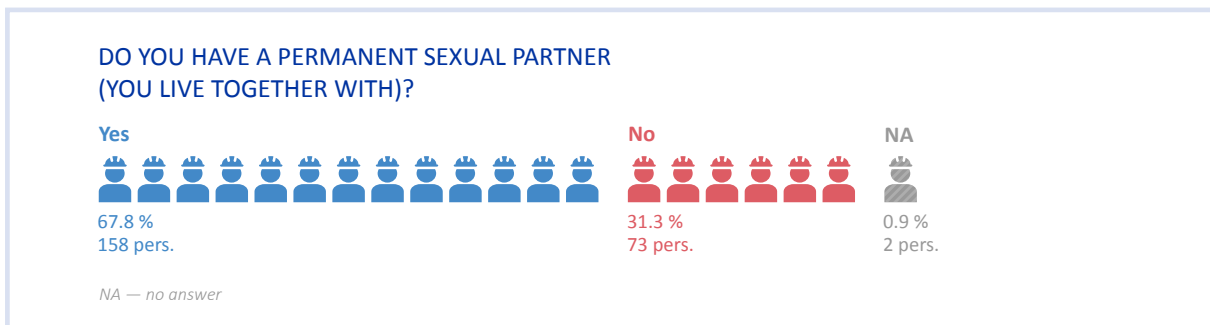


Figure 81. Availability of a regular sexual partner according to migrants

Of all the respondents who have had sexual intercourse over the past 12 months, 53.4 per cent of men and 81.6 per cent of women had a **regular sexual partner**. **Twelve per cent** of respondents (27 persons) have had sexual intercourse **with both regular and non-regular partners** over the past 12 months. Fifty-six per cent of them used a condom during the last sexual intercourse with a non-regular partner (Figure 82).

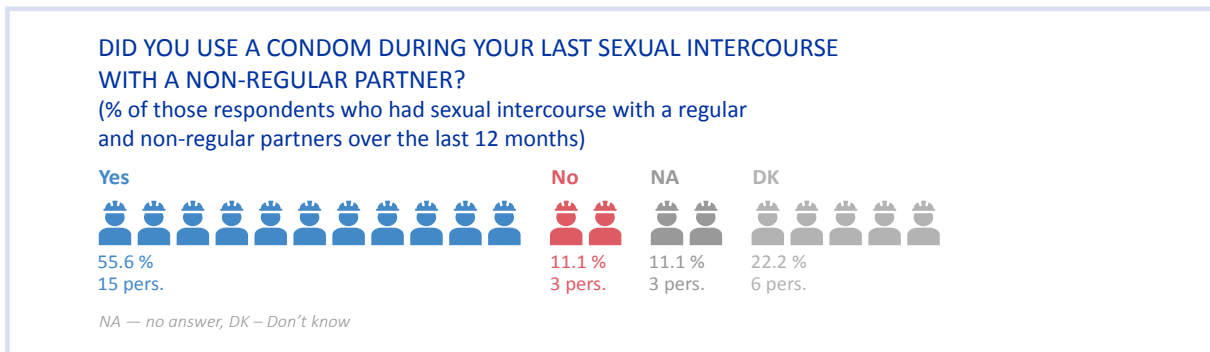
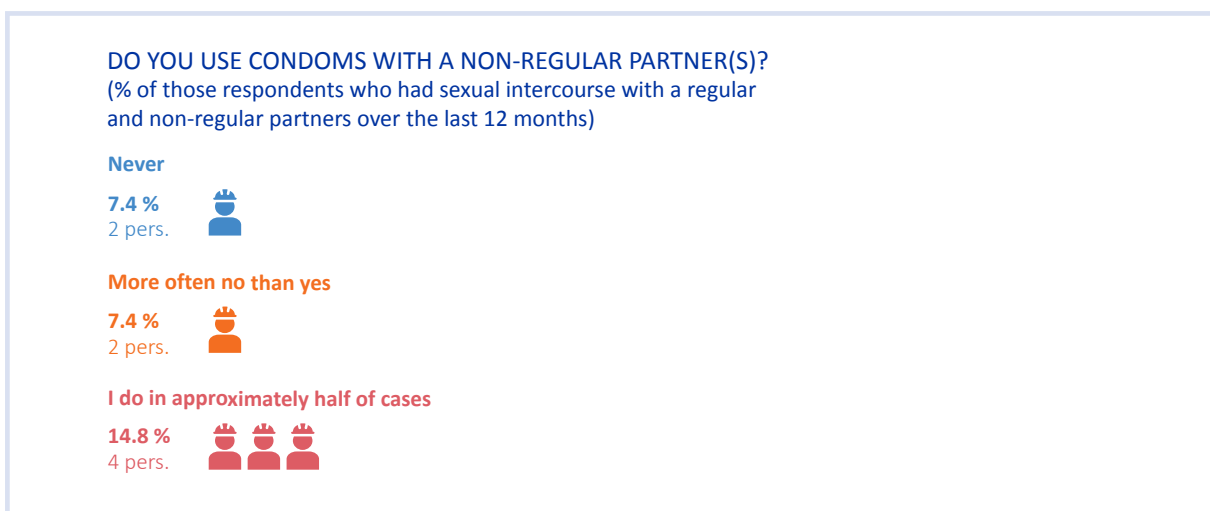


Figure 82. Condom usage during last sexual intercourse with a non-regular partner according to migrants

Thirty-seven per cent of the respondents who have had sexual intercourse **with regular and non-regular partners** over the last 12 months **always used a condom with a non-regular sexual partner** (Figure 83).



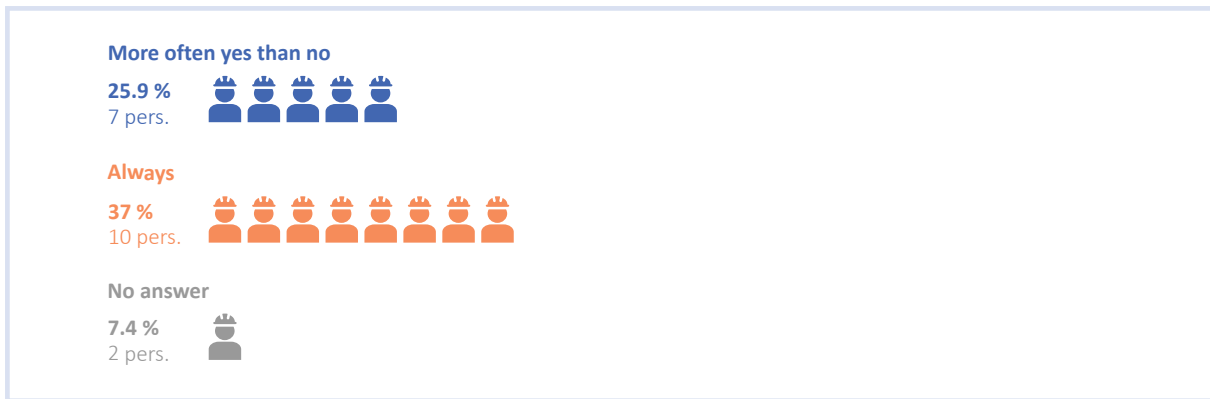


Figure 83. Frequency of condom use with a non-regular partner according to migrants

Of all respondents who have had sexual intercourse over the past 12 months, **6 per cent** (7 males and 7 females) reported **having engaged in transactional sex** (Figure 84).

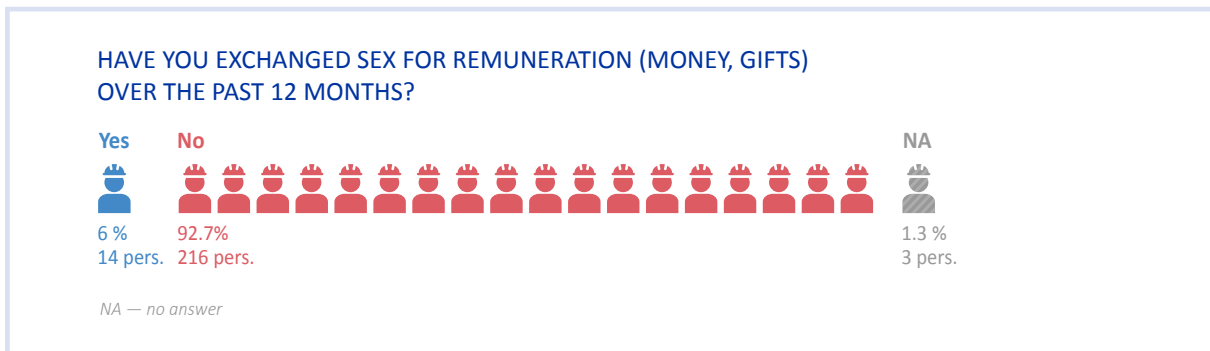


Figure 84. Distribution of migrants according to history of exchanging sex for remuneration over the last 12 months

Six persons used condoms during the last transactional sexual intercourse. Of all the respondents who have had sexual intercourse over the last 12 months, **8.6 per cent** (15 males and 5 females) **purchased sexual services** (remunerated their partners for sex). 2.1 per cent of respondents did not answer this question (Figure 85).



Figure 85. Distribution of migrants according to history of remunerating partner for sex over the last 12 months

3.5.5. Consumption of psychoactive substances

Fifty-six per cent of migrants consumed alcohol during the last month (30 days) (Figure 86). Alcohol was consumed by 68.7 per cent of men and 45.3 per cent of women.

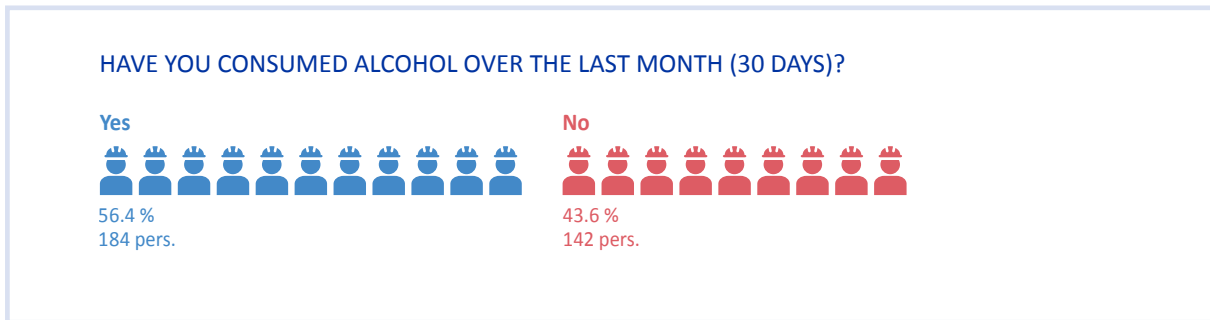


Figure 86. History of alcohol consumption over the last 30 days among migrants

Strong spirits (vodka, cognac, whisky, moonshine) are most commonly used alcoholic beverages – 49.2 per cent of those respondents who consumed alcohol in the last month drank strong spirits. As to the type of spirits, 34.4 per cent drank beer, 32.2 per cent wine and 20.8 per cent drank low-alcohol beverages (Figure 87).

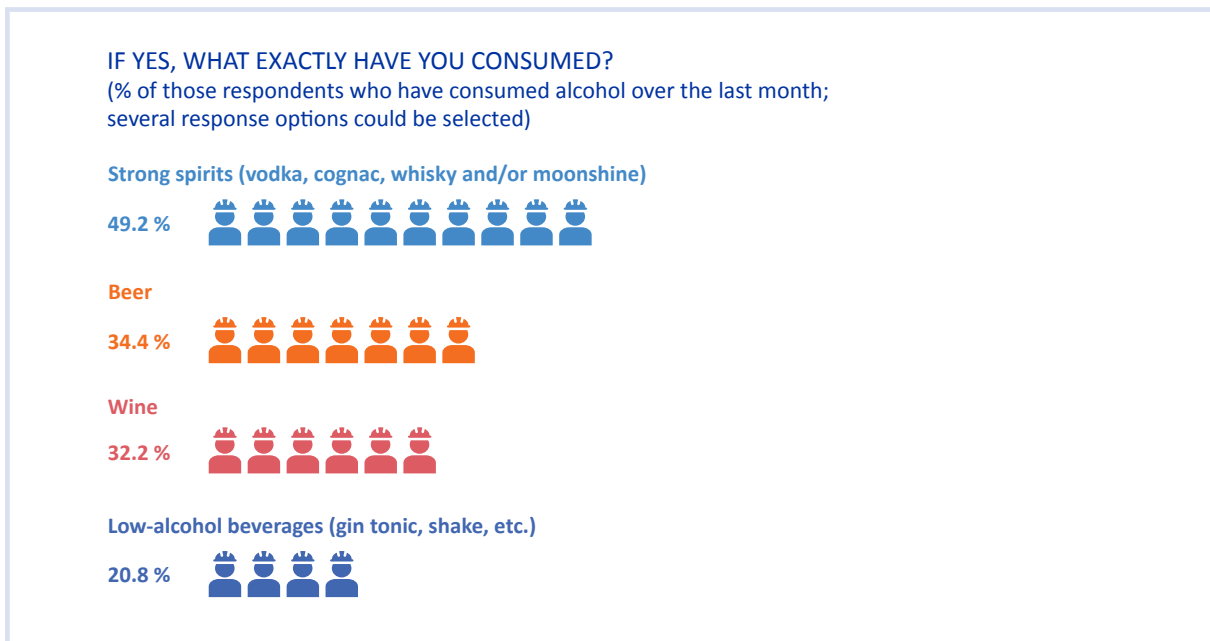


Figure 87. Alcohol preferences among migrants

Eleven per cent of migrants reported having ever used non-injection drugs (smoking blends, “weed”, pills, solutions, powders) (Figure 88).

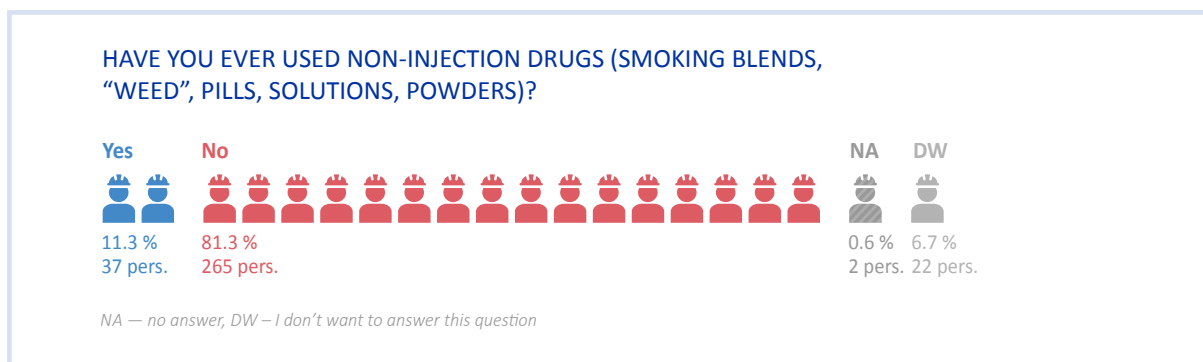


Figure 88. Distribution of migrants according to history of ever-used non-injectable drugs

Four per cent of respondents said that they had used injection drugs (once or several times). Thirteen per cent of respondents did not answer this question (Figure 89).

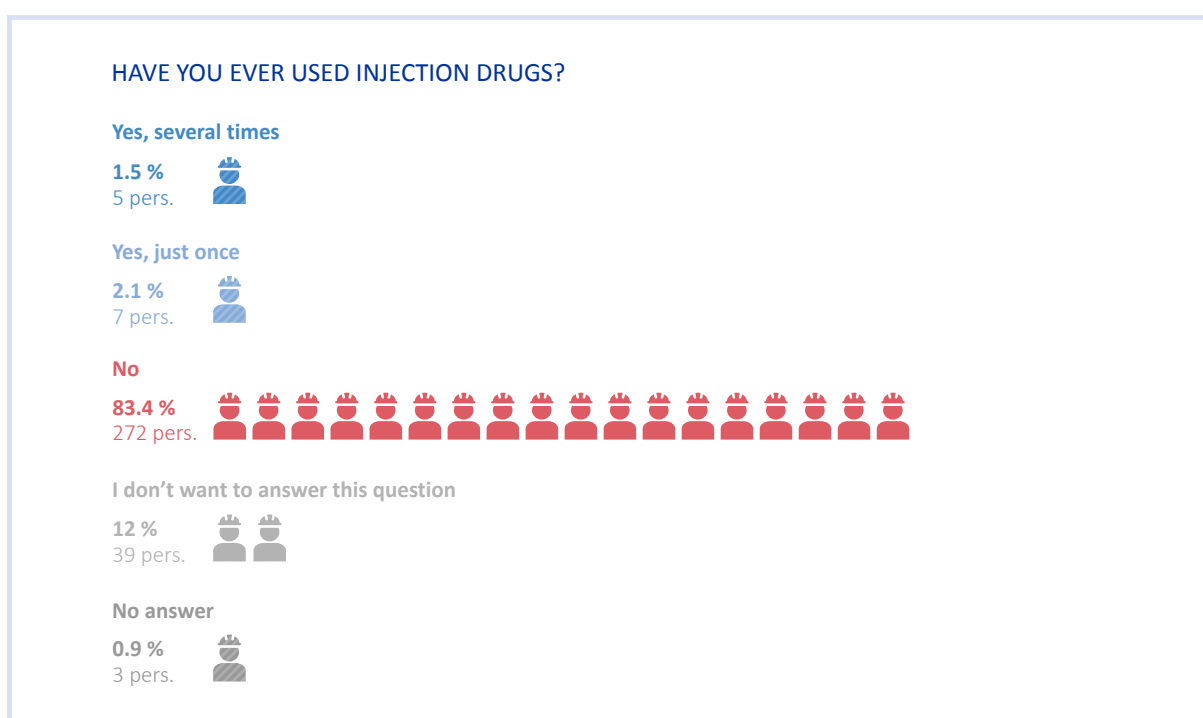


Figure 89. Distribution of migrants according to history of ever-used injectable drugs

3.5.6. HIV testing

Twenty-five per cent of migrants believe there is a real risk for them to get infected with HIV (12.4% answered “yes”, and 12.1% “more likely ‘yes’ than ‘no’”). More than half of respondents (54.8%) believe that there is no risk to become HIV-infected in their lives (28.2%) or it is “unlikely” (26.6%); 20.7 per cent of respondents failed to answer this question (Figure 90).

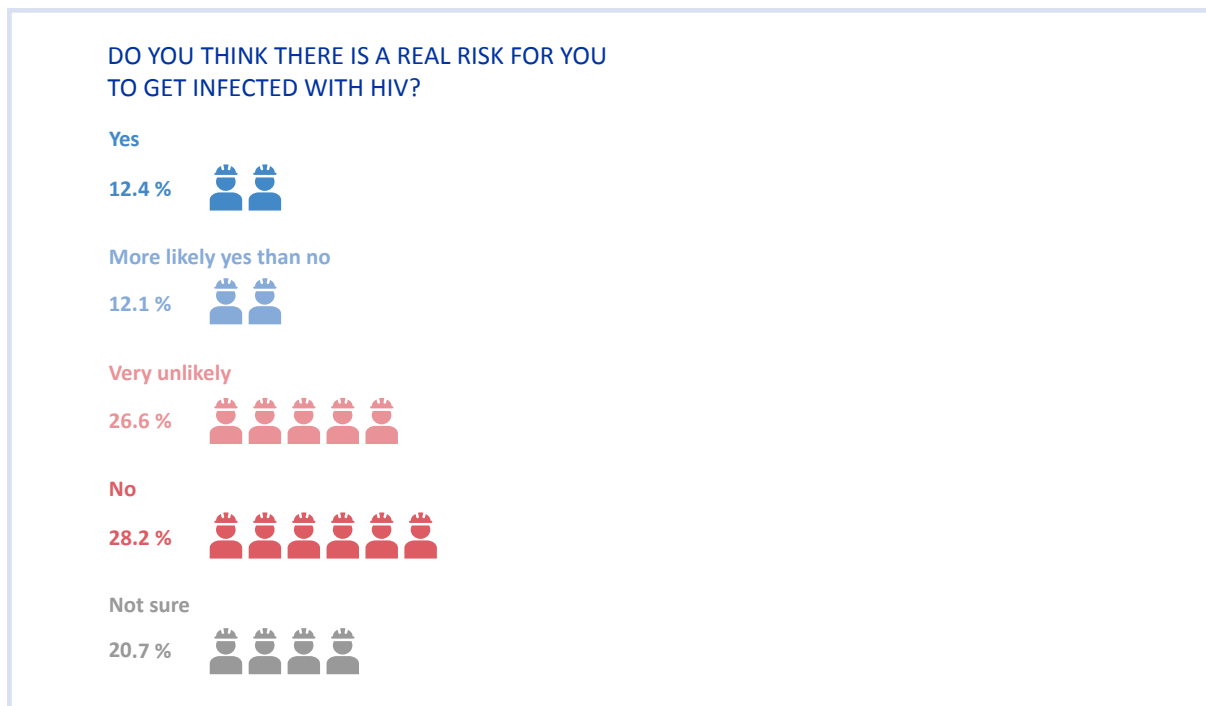
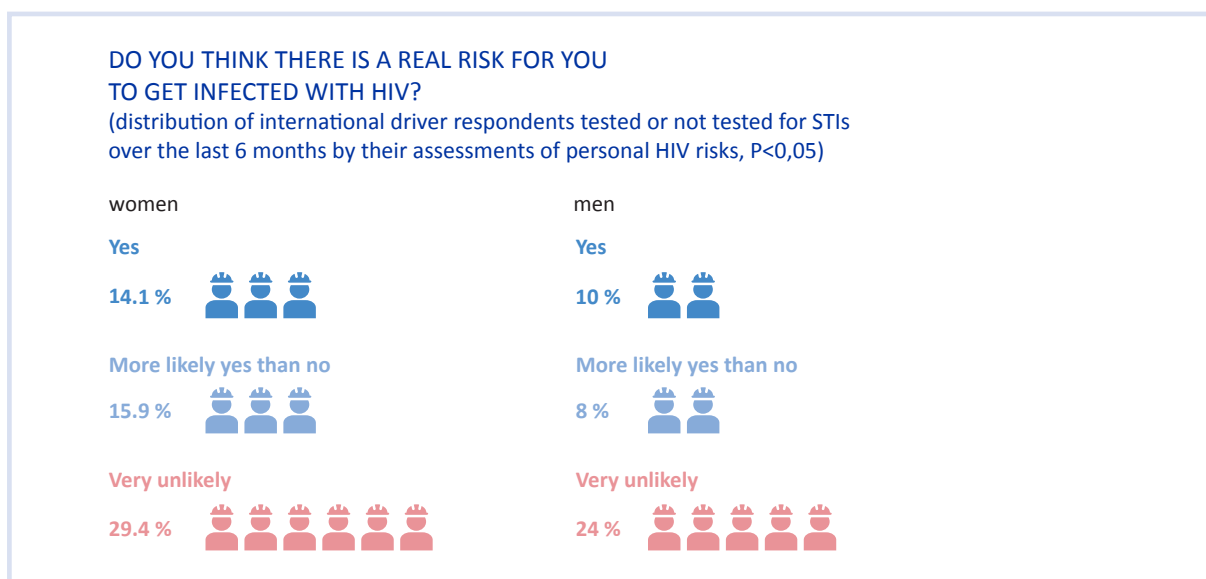


Figure 90. Perception of personal risk for getting infected with HIV among migrants

There is a certain correlation ($P < 0.001$) between the assessment of personal risk of HIV infection and the gender of respondents. The percentage of those, who believe there is such a risk, is higher among women than among men, and at the same time the percentage of those, who think there is no such a risk, is also higher among women. Thus, the percentage of respondents among men and women who believe that the risk of HIV infection exists for them personally (answers “yes” and “more likely ‘yes’, than ‘no’”) account for 30 per cent of females and 18 per cent of males. 59.4 per cent of females and 50 per cent of males consider that there was no such risk for them (answers “no” and “very unlikely”).

In general, females provide more definite answers to this question: thus, 32 per cent of men found it difficult to assess their personal risk of HIV infection compared to only 10.6 per cent of women (Figure 91).



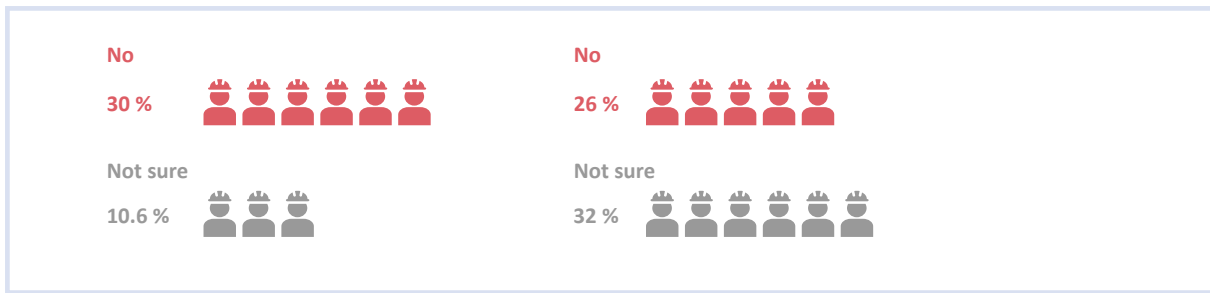


Figure 91. Perception of personal risk to get infected with HIV by gender among migrants

Sixty-three per cent of migrants indicated that they **have a possibility to get HIV tested** at the time of the survey. Twelve per cent of respondents believe that they could not get tested for HIV test at the moment of the survey; 31.5 per cent were not sure or did not answer this question (Figure 92).

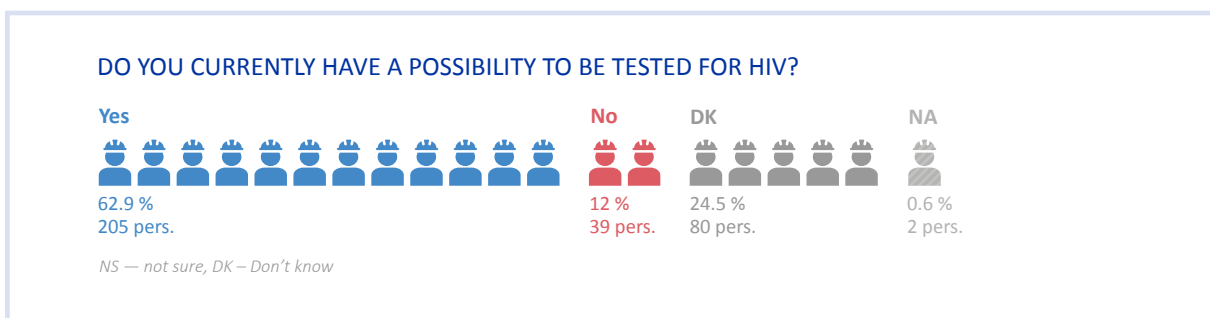


Figure 92. Perceived opportunities for getting tested for HIV among migrants

Sixty-five per cent of respondents have ever been tested for HIV. 74.5 per cent of them know the results of their tests. **Twenty-eight per cent of them have been tested for HIV over the last six months** (Figure 93).



Figure 93. Distribution of migrants according to history of having been tested for HIV during the last 6 months

Eighteen per cent of all respondents have been tested for HIV **over the last six months**. **Ninety-three per cent** of those respondents who have been tested for HIV over the last six months **know their results**. There were no significant differences revealed in the level of HIV-related knowledge between the respondents who have ever been tested for HIV and the respondents who have not.

3.6. Focus groups results among migrants residing and working in the Republic of Belarus

3.6.1. Sources of information about HIV, STIs and hepatitis C

Most participants noted that they know some people who were infected with hepatitis C one way or another, so they consider this problem as relevant for themselves. HIV infection is less relevant for them. As for STIs, they did not consider it for themselves, since they have families.

“ I heard, that some people I knew had hepatitis C. It is quite widespread now. However, it has not affected me so far.”

“ I’m often visiting hospitals now; my friend has been tested and diagnosed with hepatitis C. It might be due to her pregnancy. Though it has not concerned me and my family so far.”

“ No one is immune; we visit different facilities. My friend had a toothache very often. She went to the dentist many times, and now she has hepatitis C. Most likely she has got it through the instruments.”

“ I really want to get a tattoo, but I am afraid I can get HIV or hepatitis C.”

“ I am happy disposable syringes were invented, it reduces fears. I know some people who have HIV and hepatitis. However, we are friends; you cannot just separate from these people, they are also humans.”

Posters and booklets in polyclinics and women’s health clinics, publications in the media, and the Internet are sources of information about the diseases. A person from Gomel mentioned advertising in public transport.

“ First I received the information at a local polyclinic at my home country from posters and booklets.”

“ There is a lot of information here in polyclinics on posters and information stands; there’s also information on TV often.”

“ There is a lot of useful and accessible information at the gynaecologist’s.”

“ And I liked the advertising in the trolleybus, it was just a background, but stuck in the memory.”

Participants recall the content of the information: transmission modes, prevention measures, places where you can get advice by phone or in person, anonymously and confidentially, and get tested for HIV.

“ The main emphasis is that people should not have uncontrolled sexual activity, and drug addiction. To summarize, a syringe should be used as a medical tool only, and there must be a permanent partner in life.”

“ When I think about HIV, I see a picture of syringes and needles.”

“ I remember posters advertising anonymous testing.”

“ There’s usually a hotline number in booklets and on posters, you can call if you want to get tested, you can even get express testing. I remembered that. These hotlines — they are everywhere, you can call, you can come to get advice, you can be tested.”

If the participants need information about HIV, STIs or hepatitis C, they look it up on the internet or contact a doctor. Some respondents trust the information provided by doctors at medical facilities more.

“Dr Internet will help.”

“At the moment I would probably go to the polyclinic. Due to my pregnancy, I am visiting a doctor often now, once a week or every two weeks.”

“The Internet is somehow closer to me; there you can find out where to go further.”

“If anything happened, I would go to the infectious disease physician.”

“I trust a human being more than the Internet.”

The participants consider it **appropriate to obtain information** about HIV infection, STIs and hepatitis C **at the migration service office** through booklets or during a medical examination.

“The Migration Service is the first authority a migrant faces.”

“It seems appropriate to receive information about the diseases before medical examination.”

Concerning information about the diseases, the migrants are **interested in the following aspects: transmission modes, how to protect themselves and their families, the process of treatment, and where to go if they suspect something**. Many indicated that they lacked statistical data.

“I would like to know the difference between hepatitis and HIV, about the treatment, how long people live with the disease.”

“There should be statistics in the booklet, where and how to be tested.”

“It must contain information about the ways of transmission, preventive measure, where to go if you suddenly get sick.”

3.6.2. Behavioural risks

According to the respondents, **drug use is not common among migrants from Ukraine**, as they are constantly under close monitoring by the citizenship and migration authorities.

“We are pretty much like in the open terrain here; migration officers often visit us at our homes, we often fill in some forms, documents. So even if we wanted, it is better not to use drugs.”

“I have never met or seen Ukrainians using drugs here.”

Participants believe that **alcoholism is not very common among migrant workers either**, because if they lose their job, they must leave the country or find a new job within five days. Some mentioned the lack of money for buying alcohol. According to one respondent, alcohol consumption is mostly common in rural areas, and it is the people drinking around who are influencing mostly.

“If someone has an annual registration, then everything is connected with your job. If you do not have a job, you go home, or you have to find a new one within five days. If a man drinks here, he will be jobless, and he will have to return to Ukraine. Moreover, is there a place to go back? Therefore, there is no time to drink.”

“No money to drink alcohol.”

“When people were stressful, many of them drank, now it is more stable, and we have neither time nor money to drink.”

“I know much migrants, especially those who arrived in 2014. Those who live in a village booze a lot, because of everyone drinks, and they drink. Moreover, they are ok with such a life. In the city, people drink less.”

Concerning the **risk of transmission** of HIV, hepatitis C or STIs, most respondents indicated **providing first aid** to a person with HIV or hepatitis C, **manicure or tattooing**, and **medical procedures**, although they acknowledge that there are safety measures in place in medical facilities. The participants did not note any risks in their own behaviour.

“You could get infected if you helped an injured person who had HIV, smeared with blood and did not wash your hands afterwards.”

“You can get hepatitis through syringes.”

“If you have a blood transfusion in case there are complications during childbirth.”

“I think it is hardly possible to get an infection in a medical institution. Standards are observed there, they use disposable syringes, which are placed in a special container after use, doctors wear gloves.”

“During the manicure, if the tools are poorly sterilized.”

“You can get infected when you are getting a tattoo.”

“I think it would be only possible if my wife were unfaithful to me, but it cannot happen.”

3.6.3. Preventive measures

The respondents demonstrate a **high level of awareness of personal prevention measures**. They named using condoms with a non-regular sexual partner, avoiding drugs, and being faithful to your faithful marital partner. According to the participants, it is necessary to monitor the use of tools in medical institutions and at the hairdresser, to avoid getting tattoos.

“I have found a safe way out for myself; I am not getting tattoos.”

“One should not have uncontrolled sexual contacts.”

“I cannot imagine myself asking a man if he is healthy or not. It is necessary to use a condom in this case.”

“One should neither use drugs nor sleep around.”

“It is necessary to watch what the medical personnel are doing. If you are not sure in anything, ask them to sterilize the tools in your presence. If the person is competent, he will do everything as you ask.”

“I have a regular sexual partner, and I trust him. Transmission through needles and syringes is excluded because we do not have such friends.”

The participants noted that **condoms could be purchased almost everywhere** in Belarus, in stores and pharmacies. However, as prices are quite high, they are difficult to afford for people with low income.

“Condoms are easily available in Belarus. They are at every cash desk in stores.”

“They are not very affordable in terms of prices. A condom costs 3 roubles and more. My neighbours are young girls, they live on 15 roubles a week, and do you think they will buy condoms? Yes, they are sold everywhere, but as for the price they are not very affordable.”

“Condoms are available everywhere; they can be purchased at cash desks in stores and pharmacies.”

3.6.4. HIV testing

The majority of the participants would go to a [local polyclinic to get tested](#) for HIV, STIs or hepatitis C. Some would prefer commercial medical centres to get the results faster and to have better service.

“I would go to my polyclinic.”

“I would go to a healthcare centre where you can have all the tests done.”

“It is possible to be examined in commercial medical centres, in SINEVO, for example.”

“I would go to a commercial medical centre; it is more civilized.”

“We were tested in a small regional centre. However, we were told that it would be better to go to a commercial medical centre in Gomel, the result would be ready in two days. If you have your tests done here, the test will be sent somewhere, it will take about two weeks, then it comes back, and you will have to wait about one month in total.”

All respondents reported having been tested for HIV in Belarus, some of them several times: as they entered the country, in the employment process, as a part of prenatal care and examination.

“I was tested for HIV four times. When I arrived in Belarus it was one of the registration requirements when I applied for a job, then I was pregnant twice and tested each time.”

The participants reported that when they had been tested for HIV the blood had been taken from the vein and they had been told when to expect the results. [No one mentioned pre-test and post-test counselling](#).

“I was given an appointment card for testing. When I arrived, I was asked to fill out a questionnaire, to answer if I had any friends with HIV or hepatitis, if I had a permanent partner if I was married or single, how many children I had. After that, I had the blood taken and was told when to come. Then they gave me the result.”

“HIV testing took literally two minutes for me. I arrived, had my blood taken and was told that the results would be sent to the doctor who referred me to the test. When I received the results, the doctor did not say anything.”

Only one participant knew that it was possible to do an HIV self-test at home with the help of a saliva test, which can be purchased at a drugstore. The rest have never heard of this possibility.

“I have always believed that you can be tested through a blood test only.”

“I do not know about Belarus, but in Ukraine, it was possible to buy an HIV test at a drugstore. Moreover, here I did not ask.”

3.6.5. Results of interviews with key experts

Medical personnel noted that there had been some cases of infection among migrants reported. The sanitary service is in charge of monitoring such cases. A foreign citizen should be assigned to a local territorial polyclinic to be able to receive medical treatment and other medical assistance, which is only possible if he/she is legally staying at the territory of Belarus and has supporting documents. Foreign citizens are not provided with ART, unless the person has a residence permit in Belarus or is granted refugee status, or unless otherwise provided by an agreement with his/her country of origin. Migrants living with HIV and taking ART have to interrupt their treatment if they are placed in a temporary detention facility or resettling from a zone of armed conflict and are not able to return to their home country to replenish the stock of medicines they need.

The cost of medical services, including those for HIV treatment, is determined by the severity of the patient's condition. If there is a threat to the patient's life, assistance is provided free of charge, in other cases for a fee. If a migrant's HIV status needs to be established urgently (for example, if a migrant gets to a hospital), HIV testing is done free of charge. If a patient asks for HIV testing and there is no threat to his/her life, he/she should pay for testing. Medical personnel say they need a single document specifying the rules for the provision of medical services (such as HIV prevention, diagnosis and treatment) to various categories of migrants, including ARV prophylaxis for pregnant HIV-positive women. Currently, each case is considered on an individual basis, and there is no uniform clarification as to actions to be taken in each particular situation.

HIV testing is mandatory for several migrant groups in Belarus: international students at Belarusian universities are tested for HIV at the beginning of each academic year. HIV testing is also mandatory for migrants receiving residence permits, applying for refugee status or complementary protection, as well as for those staying in Belarus for more than three months. An employer is responsible for the medical screening of labour migrants coming to the Republic of Belarus and bears the related costs. However, there are also self-employed immigrants (artisans, individual entrepreneurs, etc.), who do not have an employer responsible for issuing permits and monitoring HIV testing requirement. There is no system to record and regulate such cases. There are no systematic activities aiming to inform foreigners about the possibility of HIV diagnostic.

Most public organizations assisting migrants provide information and advisory services to Belarusians for safe travel abroad. The Belarusian Red Cross Society works with displaced persons (Donetsk and Luhansk regions), who are granted "complementary protection" in the Republic of Belarus. Thus, they receive financial assistance in the form of "vouchers" they can use to pay for medical services, including HIV testing.

The Belarusian Public Association "Positive Movement" provides advisory services to foreign citizens on such issues as obtaining Belarusian citizenship by HIV-positive foreigners, the possibility of receiving ARV therapy in Belarus and other countries, CD4 and viral load diagnosis. Social workers and an authorized infectious disease physician provide such counselling.

The Republican Public Association "Belarusian Association of UNESCO Clubs" and Gomel Regional Organization of the Belarusian Red Cross Society implemented a series of educational activities about five years ago. They distributed condoms and information materials to international drivers at the "BAMAP-VEDY" advanced training courses within the framework of HIV/AIDS prevention project among female sex workers.

CHAPTER 4. RECOMMENDATIONS

Based on the results of the research, it is recommended that appropriate HIV prevention and treatment programmes that address the needs of migrants and mobile populations are developed and implemented in Belarus. Also, considering the very limited amount of information and knowledge on the vulnerabilities and risks faced by migrants and mobile populations in Belarus, further research on the topic is needed to inform health programmes and policies.

4.1. Recommendations on the development and implementation of HIV prevention and treatment programmes targeting migrants

Research results	Recommendations
The level of knowledge on HIV demonstrated by all target groups was not very high.	HIV awareness-raising activities should be carried out both for outgoing migrants (citizens of the Republic of Belarus going abroad to study/work) and incoming migrants (foreign citizens coming to the Republic of Belarus to study/work).
The knowledge on HIV in all target groups did not have a comprehensive character, and mostly covered HIV transmission ways, while other aspects of the disease were least known (HIV test window period, specific features of the disease itself).	Awareness-raising activities should have a comprehensive character, covering a wide range of issues in the area of HIV, hepatitis C and STIs: <ul style="list-style-type: none"> ▪ prevention ▪ diagnosis ▪ treatment
The level of the knowledge in the area of STIs and hepatitis C demonstrated by all target groups was low.	
The level of sexual risk related to contacts with non-regular partners was high in all target groups.	Prevention programmes to minimize sexual behavioural risk should be developed taking into account the following: <ul style="list-style-type: none"> ▪ specific religious, cultural, ethnic characteristics of incoming migrants; ▪ specific living conditions and behavioural risk abroad of outgoing migrants.
International drivers work in an environment where commercial sex offers are very active and even “aggressive”. The very existence of a large supply of sex services targeting drivers specifically (in the parking lots for vans and trucks along the road) may be a factor stimulating the purchase of sex services in the target group.	Active prevention campaigns should be carried out among international drivers with an emphasis on existing risks and prevention of sexual transmission of infections. It is also recommended to explore the possibilities of expanding preventive campaigns reaching out to other professional groups of persons traveling outside Belarus (construction workers, specialists working on a rotational basis).

<p>There are persons who practice commercial sex (selling and purchasing sexual services) in all target groups.</p>	<p>Prevention campaigns among other issues should also cover the risks associated with commercial sex.</p>
<p>There are behavioural risks associated with drug use in all target groups.</p>	<p>Prevention programmes should cover issues related to the use of non-injecting and injecting drugs.</p>
<p>For all target groups, it is most common to obtain information about HIV from sources other than personal communication with dedicated specialists (television programmes, visual materials, the Internet, etc.). Such information covers only the most general aspects of the problem, irrespective of a target group's specific living conditions and the behavioural risk involved.</p>	<ul style="list-style-type: none"> ▪ Public organizations having successful experience in the field of HIV prevention in the Republic of Belarus (such as Belarusian Red Cross Society, Belarusian Association of UNESCO Clubs, Positive Movement and others) should be engaged in preventive activities targeting outgoing and incoming migrants. ▪ Training programmes on HIV prevention should be implemented within the courses organized for international drivers by the training centre "BAMAP-VEDY" of the Republican Association of International Road Carriers BAMAP.
<p>The issue of personal risk to get infected with HIV has low relevance for all target groups.</p>	<ul style="list-style-type: none"> ▪ Possibilities for implementing prevention campaigns in the places where immigrants work (markets, retail chains, catering, enterprises) should be explored. ▪ Interactive forms of information work should be adopted ("peer-to-peer"). ▪ National diasporas and student communities at universities should be engaged in implementation of prevention campaigns among incoming migrants.
<p>Foreign citizens' limited knowledge of Russian or Belarusian languages can be a barrier to receive comprehensive pre-test and post-test counselling related to HIV testing.</p>	<ul style="list-style-type: none"> ▪ Special booklets containing information that is provided during pre-test counselling should be developed and translated into the languages of the main groups of migrants, to be distributed by medical workers. ▪ Interpreter services should be provided to migrants in pre- and post-test counselling to ensure direct contact between the medical specialist and the patient.
<p>The study has revealed a number of problems associated with obtaining ARV treatment by foreign HIV-positive people in emergency situations (such as fleeing a zone of a military conflict and lack of a possibility to return to the country of origin to obtain the medicines, getting into a temporary detention facility, etc.).</p>	<p>Further examination of this problem to identify solutions is recommended.</p>

<p>Incoming migrants face difficulties to access HIV testing and HIV treatment services.</p>	<p>A consolidated methodological guide for specialists (medical personnel, public organizations' staff and other interested parties) should be developed with the purpose of summarizing and clarifying the rules for the provision of medical services for HIV prevention, diagnosis and treatment to various categories of migrants, including pregnant HIV-positive women. This guide can be adjusted to be also used as an instruction on HIV prevention and treatment for migrants living in Belarus.</p>
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4.2. Further research activities

A preliminary analysis of the migration situation revealed that the population of incoming and outgoing migrants is not homogeneous and includes different groups of migrants moving in and out of the country. These groups differ both in terms of a number of demographic and socioeconomic characteristics, as well as in terms of their accessibility for research. This study covered the groups of migrants having compact locations (academic institutions, enterprises, public organizations), as well as a possibility to be gathered in groups for surveying purposes. It is further recommended to study the behavioural HIV-related risks pertinent to other groups of migrants, in particular:

- Persons travelling outside Belarus (construction workers, specialists working on a rotational basis); and
- Persons entering Belarus (working in commerce and catering, construction, industrial enterprises, IT specialists).

The following recommendations have been proposed for the purposes of further research:

- The key blocks of questions of the current research should be further used as the survey toolkit to ensure comparability and the possibility to further monitor the situation;
- Questionnaires should be translated into foreign languages to ensure participation of migrants who do not speak fluently Russian or Belarusian;
- Quantitative (questionnaire survey) and qualitative (in-depth interviews, focus groups) methods of data collection should be used;
- Migrants' behavioural risks should be specified and then broken down by regions (migrants' residence in the Republic of Belarus).

ANNEX 1

MEDICAL ASSISTANCE TO FOREIGN CITIZENS AND STATELESS PERSONS

No	Category of migrants	Emergency medical care, including HIV-related care	HIV diagnosis	HIV treatment
1	CIS citizens temporarily staying at the territory of the Republic of Belarus	Free-of-charge	To be paid	Not available
2	Foreign citizens temporarily staying in the territory of the Republic of Belarus	To be paid, by an insurance company on a medical insurance policy; in the absence of an insurance policy the expenses shall be borne by the citizen himself or by the sending/inviting party	To be paid	Not available
3	Citizens of the Russian Federation, temporarily staying and temporarily residing in the Republic of Belarus	Free-of-charge	To be paid	Not available
4	Citizens of the Russian Federation, temporarily staying at the territory of the Republic of Belarus and working in institutions (organizations) under employment contracts	Free-of-charge	To be paid	Not available
5	Citizens of Ukraine and stateless persons, who had lived at least one year, as a rule, at the territory of Donetsk and Luhansk regions of Ukraine, and arrived in the Republic of Belarus to obtain permits for temporary or permanent residence	Free-of-charge	Free-of-charge	Free-of-charge
6	Foreign nationals who have officially applied for refugee status and members of their families	Free-of-charge	To be paid	Not available
7	Minor foreign citizens who have officially applied for refugee status and members of their families	Free-of-charge	Free-of-charge	Not available
8	Foreign nationals who have been granted refugee status and members of their families	Free-of-charge	Free-of-charge	Free-of-charge
9	Foreign nationals holding a residence permit, except the citizens of Armenia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Uzbekistan	Free-of-charge	Free-of-charge	Free-of-charge
10	Citizens of Armenia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Uzbekistan holding a residence permit	Free-of-charge	To be paid	Not available
11	Foreign citizens accepted to study in the Republic of Belarus	Free-of-charge, subject to availability of a compulsory medical insurance policy, issued by a Belarusian state insurance company	Free-of-charge	Not available

ANNEX 2

DESCRIPTION OF FOCUS GROUPS

The number of participants in different target groups ranged from 4 to 16 persons (Table 1).

Table 1. List of target groups and their corresponding number of participants

Target group	Number of participants
International drivers	16 persons
International students, Minsk	7 persons (one Iranian and six Turkmen citizens)
International students, Gomel	10 persons (one Chinese and nine Turkmen citizens)
Labour migrants, Minsk	6 persons, women from Ukraine
Labour migrants, Gomel	4 persons (two men and two women from Ukraine)
Total	43 persons

All focus groups' participants (representatives of the target groups) demonstrated a high level of interest in the issues being discussed. Focus groups' participants were active, answered all questions, and supplied real-life examples. All discussions were very productive; no incidents were involved.

Limitations of the focus group method

1. When interpreting the focus groups' results, the specific nature of the focus group method should be kept in mind, as only a few respondents rather than the whole population (target group) participate. Focus group, therefore, is a qualitative method of collecting information and does not provide data characterizing the entire target group. The function of the focus group is to identify the qualitative features and nuances of the phenomena under examination or of confirming results, by studying specific cases or opinions of individual respondents in the process of group discussion.

2. A general requirement for a focus group is to ensure that the respondents are not familiar with each other. However, in the focus groups held within this project, participants knew each other (either everyone or some participants), due to the specific nature of the target groups. It was difficult to find people for a focus group who were not acquainted with each other because the participants live in the same dormitory or use the services of the same public organization. Thus, the results of the focus groups could be influenced by interpersonal communication and the relationships between the participants.

ANNEX 3

SOCIODEMOGRAPHIC PROFILE OF RESPONDENTS

A. International drivers

Table A1

Age	Number of respondents	%
21–24	13	4.8
25–29	31	11.4
30–34	51	18.8
35–39	45	16.5
40–44	36	13.2
45–49	27	9.9
50–54	22	8.1
55 and older	22	8.1
No answer	25	9.2

Table B1

Education	Number of respondents	%
Incomplete secondary (8–9 years of secondary school)	9	3.3
Secondary (10–11 years)	54	19.9
Vocational school, college or technical school	137	50.4
Higher (university level)	57	21.0
Incomplete secondary (8–9 years of secondary school)	15	5.5

Table C1

Family status	Number of respondents	%
Married officially	190	69.9
Cohabitation	24	8.8
Single	43	15.8
No answer	15	5.5

Table D1

Place of residence	Number of respondents	%
Urban area	228	83.8
Rural area	31	11.4
No answer	13	4.8

Table E1

How would you describe your financial standing?	Number of respondents	%
Excellent (I spare almost no expense)	13	4.8
Over average (mostly I have no financial difficulties)	50	18.4
Average (sometimes I have financial difficulties)	142	52.2
Below average (I have to deny myself a lot)	38	14.0
Very difficult (barely make my living)	14	5.1
No answer	15	5.5

B. International students

Table A2

Age	Number of respondents	%
17–18	31	8.8
19	54	15.4
20	76	21.7
21	69	19.7
22	41	11.7
23	23	6.6
24	21	6.0
25 and older	24	6.8
No answer	12	3.4

Table B2

Family status	Number of respondents	%
Married officially	37	10.5
Cohabitation	23	6.6
Single	270	76.9
No answer	21	6.0

Table C2

How would you describe your financial standing?	Number of respondents	%
Excellent (I spare almost no expense)	107	30.5
Over average (mostly I have no financial difficulties)	72	20.5
Average (sometimes I have financial difficulties)	107	30.5
Below average (I have to deny myself a lot)	25	7.1
Very difficult (barely make my living)	22	6.3
No answer	18	5.1

Table D2

How long have you been staying in the Republic of Belarus?	Number of respondents	%
Up to 3 months	6	1.7
3–6 months	9	2.6
Longer than 6 months, but less than 1 year	87	24.8
1 year or longer	245	69.8
No answer	4	1.1

C. Migrants

Table A3

Age	Number of respondents	%
17–24	42	12.9
25–29	45	13.8
30–34	61	18.7
35–39	56	17.2
40–44	39	12.0
45–49	25	7.7
50–54	22	6.7
55 and older	29	8.9
No answer	7	2.1

Table B3

Education	Number of respondents	%
Incomplete secondary (8–9 years of secondary school)	10	3.1
Secondary (10–11 years)	68	20.9
Vocational school, college or technical school	128	39.3
Higher (university level)	120	36.8

Table C3

Family status	Number of respondents	%
Married officially	121	37.1
Cohabitation	78	23.9
Single	126	38.7
No answer	1	0.3

Table D3

Place of residence	Number of respondents	%
Urban area	308	94.5
Rural area	17	5.2
No answer	5	1.5

Table E3

How would you describe your financial standing?	Number of respondents	%
Excellent (I spare almost no expense)	6	1.8
Over average (mostly I have no financial difficulties)	26	8.0
Average (sometimes I have financial difficulties)	152	46.6
Below average (I have to deny myself a lot)	112	34.4
Very difficult (barely make my living)	25	7.7
No answer	5	1.5

Table J3

How long have you been staying in the Republic of Belarus?	Number of respondents	%
Up to 3 months	3	0.9
3–6 months	11	3.4
Longer than 6 months, but less than 1 year	17	5.2
1 year or longer	294	90.2
No answer	1	0.3

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